

**TRICARE: Transformation of the Military Health Care System –
Demystifying Military Medicine and the Mission Impossible**

By
Barbara Hundley Zeliff

B.S., May 1990, United States Naval Academy
J.D., May 1995, Marshall-Wythe School of Law at the College of William and Mary
LL.M., December 1999, University of San Diego School of Law

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Thesis directed by
Sara Rosenbaum, J.D.
Chair, Department of Health Policy and
Harold and Jane Hirsh Professor of Health Law and Policy

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I. Introduction

*"No other single health care system has ever experienced the incredible complexities of the Defense Health Program, especially with the added challenges . . . of supporting a war."*¹

The Department of Defense's military health care system, entitled TRICARE, brings together the direct health care resources of the Department of Defense and supplements this capability through the use of managed care support services contracts and purchased care. This blended system is charged with providing a comprehensive health benefit to approximately 8.9 million beneficiaries, including active duty and retired uniformed services members, their families, and survivors, while also providing medical support to military operations.² The defense health program differs in so many ways from other employer-sponsored health plans that the label itself seems inappropriate at times, as this discretionary budget program resembles more of an entitlement than a benefit.

In the late 1980's and early 1990's, faced with escalating health care costs, a transition to managed care seemed like an understandable and natural response to what was then a national belief that market forces could improve health care quality and lower costs. The concept of managed competition proliferated as managed care took hold in the United States³ and became the cornerstone of many private and public health plans, including the Federal Employee Health

¹ *Defense Health Programs: Hearing Before Subcomm. on Total Force, House Comm. on Armed Services*, 108th Cong. (2004) (opening statement of Rep. John McHugh, Chairman) [hereinafter *Defense Health Program House Hearing 2004*].

² While the Department of Defense's military health care system provides worldwide care, this paper will specifically focus on the provision of care within the United States.

³ James A. Morone, *Populists in a Global Market*, J. HEALTH POL. POL'Y & L. 887 (1999) (noting managed competition stretches far beyond health care, and operates in a context of fierce global capitalism).

Benefit Plan (FEHBP).⁴ FEHBP has received bipartisan recognition as one of the government's more successful undertakings and a model for federal health insurance purchasing, as health care reform proposals frequently focus on expanding the FEHBP.⁵ Comparable in size to TRICARE, the FEHBP currently covers nine million active and retired federal employees and their dependents, and is the nation's largest employer-sponsored health insurance plan. Not surprisingly, some have argued the logical result would have been for the military to adopt the FEHBP as their purchased care model. Nonetheless, despite the existence of this highly regarded experience in federal health care purchasing, the defined-contribution, passive purchaser model was viewed as incompatible with the military health care system's underlying missions and design and was thus rejected.

The Department of Defense's unique approach to its health care system design, and rich benefit structure, however, in certain fundamental respects work at odds with what lies at the base of managed care theory and has limited the military health care system's ability to achieve the goals it so fervently sought. Congressional Budget Analysts have already observed that medical spending, for each dollar of cash compensation, for military members is substantially higher than it is for federal civilian employees or private-sector workers. Fiscal Year 2003 defense health spending totaled \$27.2 billion. The latest government study indicates if current trends continue, defense health-care spending could increase by roughly 50 percent to nearly double the current budget by 2020.⁶ Notwithstanding this huge investment and escalating costs, beneficiary groups and providers alike have voiced dissatisfaction and frustration with the TRICARE program.

⁴ The FEHBP "is often referred to as the original prototype of managed competition." Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1, 3 (1994).

⁵ See, e.g., the Congressional Plan put forth by Senator and putative Democratic nominee John Kerry.

⁶ CONG. BUDGET OFFICE, GROWTH IN MEDICAL SPENDING BY THE DEPARTMENT OF DEFENSE (2003), at <ftp://ftp.cbo.gov/45xx/doc4520/09-09-DoDMedical.pdf>.

Despite the best of intentions, the military health care system faces continual challenges. The very duality of the Department of Defense's health mission and the need to maintain extensive facilities and medical personnel in a permanent readiness status create a singular situation that made transformation to a competitive model of managed care more complex and difficult. System design, including a demand for customization in order to incorporate and maximize the embedded direct health care resources of the military, and heavy regulation by Congress and the Department of Defense, operated as major barriers to full market competition and limited the natural operation and power of the market. Additionally, the ever-increasing nature of both covered benefits and eligible beneficiaries has resulted in the Department of Defense having great difficulty curbing military health care costs and utilization.

The application of market purchasing strategies, which has proven elusive in the civilian market, was an even bigger disappointment in the Department of Defense system because of the constraints under which it labored. Additionally, while some of the problems experienced by the military in their transition to managed care were not all that different from other employers,⁷ the very complex transformation to TRICARE took place under the public eye with great Congressional scrutiny, and the military was not offered the same learning curve that other, less visible plans labored through. The evolution to managed care has not been a smooth one. Mistakes happen in every system⁸ but the public accounting of the Department of Defense's transformation to managed care was a unique factor.

⁷ Including network adequacy, inability to recognize and accurately predict the true cost of care, disparate benefit and cost-sharing packages for similarly situated categories of beneficiaries and beneficiary backlash due to a perception of reduced benefits.

⁸ Alain C. Enthoven and Sara J. Singer, *The Mechanics of Backlash: Unrealistic Expectations Born of Defective Institutions*, 24 J. HEALTH POL. POL'Y & L. 931, 936 (1999):

Managed care . . . is an innovation and work in progress. In response to demands by government and employers for cost containment, there is a great deal of trial and error as plans try to figure out new ways to control costs while not injuring or antagonizing patients. Mistakes are inevitable.

Further complicating this complex transformation was the public nature of the purchasing and the fact that Department of Defense beneficiaries were viewed as a special class worthy of entitlement. As a result, in many ways the military health care system shares more similarities and challenges with Medicare than they do the FEHBP, as the former programs struggle to contain rising health care costs with only a limited ability to shift costs and drive beneficiary and provider behaviors. The egalitarian-like characteristics of these two programs, coupled with heavy regulation and government cost controls limit their ability to capitalize on the advertised benefits of managed care reform. Moreover, in some aspects the military health care system has even less flexibility than the Medicare program does due to the generous and uniform nature of military health care benefits, while costs to beneficiaries have remained lower than any other federal or private employer insurance program.

This article analyzes key issues in the Department of Defense's transformation to a customized system of managed care by exploring several of the biggest issues of law and policy as they emerge from a comparison of federal health care purchasing experiences in light of the national evolution to managed health care. Particular attention is paid to system design and beneficiary and provider perspectives, as TRICARE attempts the impossible of straddling between being a discretionary budget program and earned entitlement, seeking to expand access and choice despite the goal of cost containment, and hoping to capitalize on market principles notwithstanding heavy government regulation.

In order to provide a foundation upon which to explore the Department of Defense's transformation to managed care, **Part II** focuses on the military health care system's historical framework, to include the beginnings of direct and purchased care. Particular attention will be paid to the challenge of sustaining the military health care system's dual missions of providing

peacetime care and wartime readiness, as this will lay the foundation for the vast majority of the challenges and demands for customization that arise in the Department of Defense's managed care system and eliminate the FEHBP as a possible model for the military.

Part III discusses the rise of TRICARE as a reflection of the national transformation to managed health care in the United States. TRICARE, modeled on civilian managed care organizations – including health maintenance organizations (HMOs), preferred provider organizations (PPOs) and fee-for-service options, greatly expands the Department of Defense's traditional indemnity medical benefit known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This section chronicles the legislative origins, design and implementation of TRICARE.

Part IV analyzes the experiences of the Department of Defense as it tried to make this transition to a hybrid system that combined an embedded health care structure with market purchasing principles and the challenges that arose. This section examines the added complexities of a special beneficiary class, heavy federal regulation, and the major barriers to full market participation that result from the military health care system's unique design. A brief exploration of the similarities and differences in Department of Defense's military health care system and other federal purchasing models is instructive when considering future reforms in the defense health program and federal purchase of managed care.

Finally, **Part V** evaluates current efforts at TRICARE reform through a health care market lens and raises further issues to be considered by the Department of Defense and Congress as the defense health program continues to mature and the nation seeks to control rising health care costs in the continuing transformation to managed care.

II. Military Health Care's Historical Framework - The Beginnings of Direct and Purchased Care

The military health care system is unique. The Department of Defense's approach to managed care is driven in large measure by the dual missions and historical underpinnings of the program. To appreciate the complexity of the current structure, it is necessary to have an understanding of the origins and roles of direct and purchased care within this system.

A. Supplementing Direct Care with Purchased Care (CHAMPUS)

The Department of Defense maintains its own direct health care system to provide medical treatment to active duty military members. In this sense, the direct care system functions like a large, government-administered group-practice model health maintenance organization (HMO),⁹ operating a network of hospitals and facilities and employing health care professionals around the world.¹⁰

Active duty military members are entitled to medical care in any military medical facility.¹¹ Historically, military dependents and retirees were able to receive free medical care at these military treatment facilities on a space-available basis.¹² No additional health care coverage was

⁹ Jonathan P. Weiner and Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 75, 96 (Summer, 1993) (defining a group-model HMO as one which is the sole source of care for enrollees).

¹⁰ Including 75 military hospitals and medical centers, 461 medical clinics, and 131,065 military health system personnel. DEP'T OF DEF., EVALUATION OF THE TRICARE PROGRAM FISCAL YEAR 2003 REPORT TO CONGRESS 6 (2003), at <http://www.tricare.osd.mil/planning/congress/downloads/TRICARE%20evaluation%20signed%20Apr%203%202003.pdf> [hereinafter 2003 REPORT TO CONGRESS].

¹¹ 10 U.S.C. § 1074(a) (2004).

¹² The furnishing of care is thus discretionary, vice mandatory. See 10 U.S.C. § 1074(b) and § 1076(a),(c) (2004) (relevant language tracks that of the Dependents' Medical Care Act, Pub. L. No. 89-569, §§103 and 301, 70 Stat. 250, 251 and 253 (1956), as originally enacted before codification in Unites State Code, Title 10). For a more detailed discussion of pre-1956 authorized health care, see *Schism v. U.S.*, 316 F.3d 1259, 1268-69 (Fed. Cir. 2002), *cert. denied*, 123 S. Ct. 2246 (2003).

provided by the Department of Defense.¹³

In 1956, Congress expanded military beneficiary health care for spouses and children of military members by authorizing government-financing of civilian sector health services as a way of supplementing the direct care capability of the military's treatment facilities.¹⁴ In 1966, Congress expanded the scope of medical care benefits available under the program.¹⁵ Additionally, in an effort to assure the availability of health benefits to retirees, the authorization for government-financed civilian health services was extended to retirees, their dependents and other select beneficiaries as well.¹⁶ Together, Medicare, enacted in 1965, and the Military

¹³ It is important to distinguish care provided by the Department of Defense from that provided by the Department of Veterans Affairs. There has been a considerable amount of resource sharing in recent years but a discussion of VA care is beyond the scope of this paper. For more information on VA health care in general, see Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996) and the Department of Veterans' Affairs Health Benefits webpage at http://www.appc1.va.gov/Health_Benefits/. For additional information on resource sharing between the departments, see *The Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans: Hearing Before House Comm. on Veterans' Affairs*, 108th Cong. (2003) (statement of Dr. David S.C. Chu, Under Secretary of Defense for Personnel and Readiness), at <http://www.tricare.osd.mil/planning/congress/downloads/2003%20Testimony/061703FInal%20DrChutestimony.pdf>; DEP'T OF VETERANS AFFAIRS AND DEP'T OF DEF., DOD/VA HEALTH RESOURCE SHARING AND EMERGENCY OPERATIONS ACT FISCAL YEAR 2002 REPORT TO CONGRESS (2003), at <http://www.tricare.osd.mil/planning/congress/downloads/DoD%20VA%20Sharing%20signed%20Mar%202003.pdf>; STAFF OF HOUSE COMM. ON VETERANS' AFFAIRS, 107TH CONG., DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE RESOURCE SHARING (Comm. Print 2002), at <http://veterans.house.gov/about/vadod/vadodsha.pdf>; GEN. ACCOUNTING OFFICE, VA AND DEFENSE HEALTH CARE – EVOLVING HEALTH CARE SYSTEMS REQUIRE RETHINKING OF RESOURCE SHARING STRATEGIES (2000), at <http://www.gao.gov> (retrievable by Report # GAO/HEHS-00-52).

¹⁴ MARY E. ANDERSON ET AL., RAND CORP., PUB. NO. R-4244/6-HA, EVALUATION OF THE CHAMPUS REFORM INITIATIVE 3 (1994), at <http://www.rand.org/publications/R/R4244.6/>. See Dependents' Medical Care Act, Pub. L. No. 85-569, § 201, 70 Stat. 250, 252 (1956). The contents of this Act were subsequently codified in chapter 55 of Title 10 of the United States Code by Pub. L. No. 85-861, 72 Stat. 1437, 1445-51 (1958) (and amended numerous times since then). Interestingly, this program was originally referred to as Medicare until the larger Social Security Administration program preempted the name. COMPTROLLER GEN. OF THE U.S., B-133142, SUMMARY REPORT TO THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES, POTENTIAL FOR IMPROVEMENTS IN THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES, 4 (1971), at <http://www.gao.gov> (retrievable by Decision # B-133142) [hereinafter SUMMARY REPORT].

¹⁵ Available care was expanded from diagnosis, treatment of acute medical and surgical conditions and contagious diseases, immunizations, and maternity and infant care to include broad entitlements to hospitalization, outpatient care, physical examinations, diagnostic tests and services, mental health treatment, drugs, durable equipment and dental care. Military Medical Benefits Amendments of 1966, Pub. L. No. 89-614, § 2(4), 80 Stat. 862, 863 (1966) (codified at 10 U.S.C. § 1077).

¹⁶ § 2(7), 80 Stat. at 865 (codified at 10 U.S.C. §1086). In requesting this authority, the Secretary of Defense explained:

The purpose of the proposed legislation is to provide a program of health benefits equally available to all retired members of the uniformed services and their dependents. Such a program

Medical Benefits Amendment Act of 1966 were designed to provide comprehensive coverage to military retirees, with coverage provided through the Department of Defense until Medicare eligibility at the age of sixty five.

The authority permitted the Secretary of Defense to contract for medical care “under such insurance, medical service, or health plans as he considers appropriate.”¹⁷ Despite this breadth of this authority, the Department of Defense limited its program to one of direct purchasing of civilian medical services, vice purchasing full health plans or commercial insurance for its beneficiaries.

The civilian-sourced medical benefits program was redesignated the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) on January 1, 1967, when the amendments became effective.¹⁸ For the next twenty years, the Department of Defense supplemented its direct care system with the purchase of health services furnished by civilian health care personnel through CHAMPUS’ fee-for-service program. This program, in large part, mirrored that of other private and public self-insured health care programs by requiring participants to share in the costs of care through deductibles and co-pays.¹⁹ The Department of Defense, through the Civilian Health and Medical Program of the Uniformed Services Office (OCHAMPUS), contracted on a cost-reimbursement basis with fiscal agents, including various Blue Cross and Blue Shield agencies, insurance companies, and medical societies to process and

is required to provide equitable benefits to our rapidly increasing retired population. In future years, these benefits must increasingly be provided by civilian institutions due to the declining coverage of space-available care in military facilities.

Schism v. U.S., 316 F.3d 1259, 1268-69 (Fed. Cir. 2002), *cert. denied*, 123 S. Ct. 2246 (2003), (quoting from H.R. REP. NO. 89-1407, at 27 (1966)).

¹⁷ Military Medical Benefits Amendments of 1966 § 2(6) and (7), 80 Stat. at 863 and 865 (codified as amended at 10 U.S.C. §1079 and §1086).

¹⁸ SUMMARY REPORT, *supra* note 14, at 4.

¹⁹ ANDERSON, *supra* note 14, at 4. The Standard CHAMPUS benefits and coverage information is located in the first column of Table 1. *Id.*

pay virtually all CHAMPUS claims for medical care.²⁰ In essence, beneficiaries received care through a combination of the Department of the Defense's self-administered HMO, known as the direct care system, and an added point of service option to receive health care from civilian health professionals on a fee-for-service basis under CHAMPUS.

The provider compensation principles that governed CHAMPUS²¹ paralleled those used in civilian insurance programs,²² including Medicare. Similarly to the early experiences of Medicare,²³ charges for "selected medical procedures ... increased as much as 70 percent in some [s]tates."²⁴

B. The Rising Cost of Purchased Care

As early as 1969, substantial increases in CHAMPUS costs had raised concerns in Congress and the Comptroller General of the United States was asked to conduct a review.²⁵ The comprehensive review confirmed costs had risen from \$33 million at the start of the program in fiscal year 1957 to over \$237 million in fiscal year 1970.²⁶ The increases were due to a combination of the 1966 expansion of benefits and eligible beneficiaries, increased costs of medical care in general, and increased use of the program.²⁷ Increased usage of the program was

²⁰ SUMMARY REPORT, *supra* note 14, at 6.

²¹ CHAMPUS adopted the "reasonable-charge" concept for paying physicians for CHAMPUS claims. SUMMARY REPORT, *supra* note 14, at 18 ("a physician receives his customary charge for each service rendered, as long as it is within the prevailing level of charges made for the service by other physicians in the same locality").

²² See Weiner & Lissovoy, *supra* note 9, at 76:

At the onset of the decade . . . [a]bout 90 percent of working Americans and their dependents were covered by conventional "indemnity" health insurance plans . . . consumers were free to choose any available provider. Physicians . . . were faced with few constraints and practiced more or less as they wished. Insurance companies usually served as passive go-betweens . . . [w]ith little scrutiny they paid bills submitted to them on a fee-for-service (FFS), retrospective basis.

²³ See RAND E. ROSENBLATT, SYLVIA A. LAW & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM 513-15 (1997).

²⁴ SUMMARY REPORT, *supra* note 14, at 19.

²⁵ Letter from Representative George H. Mahon, Chairman, Committee on Appropriations, House of Representatives, to the Honorable Elmer B. Staats, Comptroller General of the United States (Oct. 20, 1969), reprinted in SUMMARY REPORT, *supra* note 14, at 57-58.

²⁶ SUMMARY REPORT, *supra* note 14, at 1.

²⁷ *Id.* at 2.

due in part to staff shortages at military hospitals and treatment facilities which necessitated the increased issuance of nonavailability statements²⁸ and directing of patients away from military treatment to more expensive CHAMPUS covered fee-for-service care.²⁹

C. Reduced Capacity in the Direct Care System

By the late 1970s, the Department of Defense experienced great shortfalls in its ability to provide direct medical care at military treatment facilities due to an insufficient number of military physicians following the end of the draft.³⁰ This shortage, and the Department's resulting reduced ability to provide care to qualified beneficiaries, necessitated a reevaluation of both the mission and design of the military health care system in an effort to find the optimal mix of direct and purchased health care.³¹

D. The Challenge of Sustaining Military Health Care's Dual Missions

Any discussion concerning health care reform within the military context must begin with an examination of the purpose of the military health care system. The Department of Defense is tasked with two distinct, yet symbiotic, missions: maintaining wartime/operational readiness and providing peacetime health care for military personnel, retirees, and their families.³² The

²⁸ In an effort to prevent the unnecessary use of civilian care when capacity was available in the military's direct care program, nonavailability statements were required before dependents of active duty personnel were entitled to utilize CHAMPUS benefits.

²⁹ SUMMARY REPORT, *supra* note 14, at 39.

³⁰ For a more detailed discussion, see COMPTROLLER GENERAL OF THE U.S., REPORT TO CONGRESS B-133044, MILITARY MEDICINE IS IN TROUBLE: COMPLETE REASSESSMENT NEEDED, i-v and 4-8 (1979) [hereinafter MILITARY MEDICINE IS IN TROUBLE].

³¹ "We [the Department of Defense] concur ... that a severe gap exists between the number of military physicians needed and the number available to render care to the beneficiaries of the Military Health Services System, that this shortage has had adverse effects on its responsiveness to military beneficiaries, and that there is a need to reevaluate the role and structure of the Military Health Services System." Letter from Vernon McKenzie, Principal Deputy Assistant Secretary of Defense for Health Affairs, to Gregory J. Ahart, Director, Human Resources Division, General Accounting Office (Jul. 9, 1979), reprinted in MILITARY MEDICINE IS IN TROUBLE, *supra* note 30, at 63-64.

³² The Department of Defense's Health Affairs website currently articulates the mission as follows: "to provide, and to maintain readiness to provide, healthcare services and support to members of the Armed Forces during military operations. In addition, the Department's healthcare mission provides healthcare services and support to members of the Armed Forces, their family members, and others entitled to DoD healthcare." at <http://www.ha.osd.mil/about/default.cfm>.

military medical departments were originally created to maintain the health and readiness of active duty military members and to be prepared to deploy and treat casualties during war and other military operations.³³ For some compelling accounts regarding the diverse capabilities, successes and immeasurable value of the wartime readiness of military health care professions, one need only look to their most recent service in support of Operation Iraqi Freedom.³⁴

In addition to maintaining active duty medical readiness, the Department of Defense provides health care benefits to a large beneficiary population, as a condition of members' service.³⁵ This peacetime health care mission utilizes the excess capacity in the direct care system and supplements it with purchased civilian care.

³³ To that end, the Department of Defense has articulated its military medical readiness training policy as follows: It is DoD policy that the appropriate training of military medical personnel is the foundation for effective force health protection. Training must encompass all aspects of medical support in combat, humanitarian, and homeland defense contingencies and military medical personnel must be able to provide health services support in all types of environments.

DEP'T OF DEF., INSTRUCTION 1322.24, MILITARY READINESS TRAINING, 2 (July 12, 2002), at <http://www.dtic.mil/whs/directives/corres/html/132224.htm>.

³⁴ See, e.g., Arlo Wagner, *Medical Personnel Deploy to Ship: Navy Sends 400 to USNS Comfort*, WASH. TIMES, March 17, 2003, at B1 (reporting an additional 400 Navy medical personnel left the US to join the USNS Comfort, a 1,000 bed hospital ship, currently deployed in the Indian Ocean, to bring the ship to a full compliment of 1,200 medical and hospital support members in anticipation of war in Iraq); Jonathan Bor, *An Injured Marine Takes Stock after Bloody Battle; Aboard USNS Comfort, Healing Gets Under Way*, BALTIMORE SUN, March 23, 2003, at 1A (covering surgical treatment provided on board the hospital ship to Marines with combat injuries); Richard Beeston, *Move Over M*A*S*H – this is Hi-Tech C*A*S*H*, TIMES (LONDON), November 15, 2003, at 22 (an imbedded reporter covers the 21st Combat Support Hospital operating in Balad, Iraq and the fact that many soldiers who would have died of combat wounds are now saved by advances in battlefield medicine and rapid treatment in Combat Support Hospitals); Neela Banerjee, *The Struggle for Iraq: The Wounded; Rebuilding Bodies, and Lives, Maimed by War*, N.Y. TIMES, November 16, 2003, at 1 (focusing on treatment of war amputees at Walter Reed Army Medical Center in Washington, D.C.); *Injured Troops Return from Iraq: New Medic Training Reducing Combat Deaths* (CNN Newsnight Aaron Brown 22:00 television broadcast, December 24, 2003) (transcript #122400CN.V84) (chronicling treatment of injured American soldiers in forward fields hospitals, at Landstuhl Regional Medical Center in Germany and those ultimately air lifted back to military hospitals in the United States for further treatment); *Work of the 28th Combat Support Hospital in Baghdad* (NPR All Things Considered 9:00 ET radio broadcast, January 15, 2004) (examining the unit's 10 months of service in Iraq, from tent hospitals in the middle of the desert to facilities in Baghdad to provide frontline care to combat wounded). All sources cited are at LEXIS, News Library, CURNEWS File. See also *Force Health Protection and Surveillance Efforts for Service Members Deployed to Operation Enduring Freedom and Operation Iraqi Freedom: Hearing Before Total Force Subcomm., House Comm. on Armed Services*, 108th Cong. (2004) (statement of The Honorable William Winkenwerder, Jr., M.D., M.B.A., Assistant Secretary of Defense for Health Affairs and Lieutenant General James B. Peake, M.D., The Surgeon General, U.S. Army Commander, U.S. Medical Command) (testifying that medical care is available within minutes with a 98 percent survival rate for those wounded in combat).

³⁵ These statutorily created benefits are considered critical to military families' quality of life and a powerful inducement for military enlistment.

Policy analysts may wonder why, with two clearly distinct missions, the system would not naturally bifurcate into a direct care system for active duty members and a standard system of purchased care for other beneficiaries. The answer, in the Department of Defense's view, is that the missions are inextricably intertwined.³⁶ The military direct care system needs volume and constancy in order to maintain its readiness capabilities. There is a concern that severing the two systems will result in the inability to properly train for wartime operations. As a result, the Department of Defense has repeatedly urged that:

Failure to deal with this relationship [between the wartime/contingency readiness mission of the Military Health Services System and the health benefit mission], implies the conceptualization of the system into two discrete and separate entities leading to analyses and conclusions that ignore the dual mission. Alternative proposals which ignore the dual mission can result in the solution of one mission problem to the detriment of the other mission.³⁷

Thus, the basic ground rules of system design were set well before the advent of managed care. Throughout the transition to managed care, and to the present time for that matter, the Department of Defense has remained steadfast in its convictions regarding military facilities' active involvement in civilian beneficiary treatment.³⁸

These dual missions are both what makes the military health care system unique, and what serves at times to extraordinarily complicate the Department's attempts to migrate to an

³⁶ *Military Health System: Hearing Before the Subcomm. on Total Force, House Comm. on Armed Services*, 108th Cong. (2003) (statement of Dr. William Winkenwerder, Jr., MD, MBA, Assistant Secretary of Defense (Health Affairs)), *at* <http://www.tricare.osd.mil/planning/congress/downloads/2003%20Testimony/040303FINAL%20Dr.Winkenwerderstatement%20.pdf> [hereinafter *Military Health System Hearing 2003*].

³⁷ Letter from Vernon McKenzie, Principal Deputy Assistant Secretary of Defense for Health Affairs, to Gregory J. Ahart, Director, Human Resources Division, General Accounting Office (Jul. 9, 1979), *reprinted in MILITARY MEDICINE IS IN TROUBLE*, *supra* note 30, at 63-64. See also Memorandum from Paul Wolfowitz, Deputy Secretary of Defense, to Assistant Secretary of Defense (Health Affairs) 14 (Jan. 20, 2004), *at* http://www.ha.osd.mil/policies/2004/tricare_governance_guidance.pdf (directing execution of the TRICARE governance plan to ensure among other things the integration of the direct care system with purchased care).

³⁸ GEN. ACCOUNTING OFFICE, REPORT TO CONGRESS # GAO/HEHS-98-68, OFFERING FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM TO DOD BENEFICIARIES, 6 (1998), *at* <http://www.gao.gov> (retrievable by Report # GAO/HEHS-98-68) [hereinafter OFFERING FEHBP TO DOD] ("DoD officials have stated that retaining sufficient numbers and an appropriate mix of patients in the DoD system is critical to recruiting, retaining, and training military physicians and support staff for wartime readiness.").

integrated system of managed health care, including efforts to convert CHAMPUS much more heavily to a system of competitive purchasing of civilian services.³⁹ Challenges have included the appropriate emphasis to be placed on direct versus purchased care, how to allocate limited resources amongst them, and ultimately the proper balance between the two to ensure access to cost-effective and timely quality medical care, without sacrificing military readiness.

The transformation of peacetime health care from what was considered a space-available benefit to entice enlistment, to a virtual right or entitlement, via enactment of statutory authority to provide purchased care, created tension.⁴⁰ As a result of the increased demand for peacetime care, and related pressure to provide that care in-house in order to contain costs, the system has a tendency to become skewed away from its primary wartime mission to one focused primarily on providing direct peacetime beneficiary care.⁴¹

Problems continued well into the 1980s for the military health system. Congressional

³⁹ See SUSAN D. HOSEK AND GARY CECCHINE, RAND CORP., PUB. NO. MR-1350-OSD, REORGANIZING THE MILITARY HEALTH SYSTEM: SHOULD THERE BE A JOINT COMMAND? 3 (2001), at <http://www.rand.org/publications/MR/MR1350/>. (“Although the two missions complement one another, joint production of readiness and benefits involves a complicated set of trade-offs and management challenges.”); *Observations on Proposed Benefit Expansion and Overcoming TRICARE Obstacle : Hearing Before the Subcomm. on Military Personnel, House Comm. on Armed Services*, 106th Cong. (2000) (statement of Stephen P. Backhus, Director, Veterans’ Affairs and Military Health Care Issues, Health, Education, and Human Services Division, Gen. Accounting Office), 3, at <http://www.gao.gov> (retrievable by Report # T-HEHS/NSAID-00-129) [hereinafter *Observations on Proposed Benefit Expansion Hearing*] (“It is because of this dual role that DoD is often challenged in providing health care”).

⁴⁰ S. REP. NO. 99-331, at 243 (1986).

⁴¹ See, e.g., *id.* at 243 (1986) (highlighting the “slow but steady shift in emphasis . . . from its primary mission of wartime medical care toward becoming a peacetime birth-to-death medical care system for more than 10 million beneficiaries, only some 25% of which are active duty military personnel”).

See also H.R. REP. NO. 99-718, at 234 (1986):

Following the Vietnam war, the dual missions of military medicine received decidedly unequal emphasis. Specifically, the services devoted far more attention to the peacetime benefit missions – to the detriment of wartime medical readiness. Rather than using scarce medical resources to acquire surgeons in critical wartime specialties, for example, the services accessed, trained, and retained a disproportionate number of family-oriented physicians. As a result, the Army today has only 41 percent of its wartime need for orthopedic surgeons but 5,409 percent of the pediatricians required for war.

See also H.R. REP. NO. 100-58, at 207 (1987) (complaining a insufficient emphasis has been placed on medical readiness since the end of the Vietnam conflict and describing “medical manpower shortages as serious ‘war-stoppers’”).

scrutiny concluded the Department of Defense was failing in the performance of both missions.⁴²

The Department of Defense was faced with the failure of their direct care system coupled with skyrocketing costs of CHAMPUS, which was consistent with what was occurring nationally at the time in fee-for-service plans.⁴³

This predicament highlighted the need to transform the military health care system and led to a search for solutions as the nation also confronted the need for health care reform. While various public and private models existed, true health care reform on a large scale did not occur until the 1980s.⁴⁴ Managed care arose as a “collective response on the part of both public and private payers to mounting evidence of out-of-control health care costs which threatened the future of health insurance, as well as studies showing widespread evidence of expensive care of questionable quality.”⁴⁵

III. TRICARE - The Customized Development of Managed Care Options within the Department of Defense

⁴² See H.R. REP. NO. 99-718 at 234 (1986):

The committee is extremely concerned about the current state of the military medical care system. As part of its oversight responsibility, the committee conducted an extensive review of military medicine over the last several years in an effort to evaluate whether the military medical care system is capable of effectively executing its dual mission Unfortunately, the committee has concluded that the system is currently incapable of performing either mission adequately.

Similarly, the United States Senate Committee on Armed Services concluded:

In short, the committee has little doubt that the present military medical system is not working well. At the same time, the committee does not believe this is the fault of the men and women who labor in that system. Rather, *the system merely was not planned, designed, or constructed to provide efficiently the care now required by the military beneficiary population.*

S. REP. NO. 99-331, at 243-44 (1986) (emphasis added).

⁴³ Drew E. Altman and Larry Levitt, *The Sad History of Health Care Cost Containment as Told in One Chart*, HEALTH AFFAIRS (January 23, 2002), at

http://www.kaisernetwork.org/health_cast/upload_files/AltmanLevittHealthAffairsArticle.pdf (web exclusive).

⁴⁴ Weiner & Lissovov, *supra* note 9, at 76.

⁴⁵ ROSENBLATT, *supra* note 23, at 546.

In many ways, the impetus for transformation of the military health care system mirrors that of the public and private sector, driven in large measure by concerns over escalating costs and access to quality health care. The approach taken, however, is a complex and highly customized one. The very duality of the Department of Defense health mission and the need to maintain extensive facilities and health care personnel in a permanent readiness status created a situation that made transformation to a competitive model difficult.

A. Other Federal Purchasing Models

Managed care models gained popularity not only in the private insurance industry but in federal and state programs as well, including Medicare, Medicaid and the Federal Employees Health Benefit Plan (FEHBP). Despite the fact that three federal programs, CHAMPUS, the FEHBP,⁴⁶ and Medicare⁴⁷ were all enacted within several years of each other, and were patterned after the traditional fee-for-service health benefit model, they evolved rather independently over the ensuing decades as health care costs rose and managed care principles took hold. One need only take a cursory look at these three systems to notice their diversity in structure and design of federally financed health care for their respective beneficiary populations.⁴⁸

Medicare, the nation's largest health insurance program, is a heavily regulated entitlement program⁴⁹ that provides an absolute guarantee of health care coverage to beneficiaries who are

⁴⁶ FEHBP was created in 1959 to provide federal employees with comprehensive health care benefits. Pub. L. No. 86-382, 73 Stat. 708 (1959).

⁴⁷ Medicare was enacted in 1965. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended at 42 U.S.C. Title XVIII).

⁴⁸ GEN. ACCOUNTING OFFICE, GAO/HEHS-98-231R, COMPARISON OF FEDERAL HEALTH PROGRAMS (1998), *at* <http://www.gao.gov> (retrievable by Report # HEHS-98-231R) [hereinafter COMPARISON OF FEDERAL HEALTH PROGRAMS].

⁴⁹ See *id.* at 12 (comparing the number of statutory and regulatory pages for Medicare, FEHBP and DoD). For a more detailed discussion of Medicare regulation and preemption issues, see Michael J. Jackonis, *Considerations in Medicare Reform: The Impact of Medicare Preemption on State Laws*, 13 ANNALS HEALTH L. 179 (2004).

65 or older, disabled, or have end-stage renal disease.⁵⁰ Sometimes described as an egalitarian system, Medicare benefits are heavily subsidized by the federal government and distributed primarily based on need vice ability to pay or anticipated risk.⁵¹ Operating largely as a fee-for-service model, with the federal government acting as a traditional insurer for beneficiaries, reimbursing private providers who provide statutorily covered benefits, the government has had difficulty constraining costs.⁵²

Medicare's transition to managed care has lagged behind that of other federal programs and private employer-sponsored health care. By 1997, only 15 percent of beneficiaries were enrolled in an HMO.⁵³ Additional health plan options were provided to Medicare beneficiaries in 1999, when Medicare+Choice (M+C) began providing beneficiaries with a choice of enrolling in private health plans as an alternative to traditional Medicare fee-for-service.⁵⁴ Beneficiaries were enticed to enroll based on the promise of enhanced benefits, such as coverage of prescription drugs and other benefits not covered by traditional Medicare. Medicare's managed care program, M+C, has suffered its share of problems,⁵⁵ however, and health plans have become

⁵⁰ 42 U.S.C. §§1395c, 1395j (2004).

⁵¹ ROSENBLATT, *supra* note 23, at 374.

⁵² E.g., Uwe E. Reinhardt, *Perspectives on Medicare; Demagoguery and Debate Over Medicare Reform*, HEALTH AFFAIRS, Winter 1995, at 101 (discussing what have been labeled as "serious design flaws" in Medicare: "it is an open-ended, defined-benefit program whose cost can be controlled only by capping the fees paid by the program. There is no practical means of controlling the volume of services billed to the program.").

⁵³ COMPARISON OF FEDERAL HEALTH PROGRAMS, *supra* note 48, at 3-4.

⁵⁴ Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997).

⁵⁵ E.g. Barbara S. Cooper, The Commonwealth Fund, *Medicare's Future: Current Picture, Trends, and Medicare Prescription Drug Improvement & Modernization Act of 2003* 24 (2004), at http://www.cmwf.org/programs/medfutur/medicarehtpk_debate_659.pdf: highlighting what are perceived as M+C failures:

- Private plans do not participate in many states and geographic areas
- Wide geographic variability in premiums and benefits
- Unstable participation by private plans and providers
- High out-of-pocket burden on sick
- No standard benefit; impossible to compare plan benefits

Id. at 25.

less willing to participate in M+C.⁵⁶ With the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003,⁵⁷ it remains to be seen whether a market will emerge for private retirement health care plans under Medicare Advantage.⁵⁸

By contrast, the Federal Employees Health Benefit Plan, a premium support model, is cited as a model of success and basis for federal health care reform proposals.⁵⁹ Under this model, the government acts as an insurance purchaser vice insurer and thus in many ways mirrors private employers. The Office of Personnel Management contracts annually with private health insurance carriers to provide coverage to federal employees.⁶⁰ All qualified carriers are eligible to participate in FEHBP. Under this program, “[t]he government relies heavily on market competition and consumer choice to provide [its] members with comprehensive, affordable health care.”⁶¹ The underlying premise of managed competition is to provide beneficiaries with the freedom to choose between a range of health care plan options, “in an environment that manages the selection process and makes individuals pay for the differences in price among the insurance options they choose.”⁶² Beneficiaries, in turn, can exercise freedom of choice with some appreciation of the relative costs.⁶³

⁵⁶ Jacksonis, *supra* note 49, at 190-92. Enrollment in M+C peaked at 6.3 million in 1999. JENNIFER STUBER ET AL., CTR. FOR HEALTH SERVS. RESEARCH AND POLICY, GEORGE WASHINGTON UNIV. MED. CTR., NATIONAL AND LOCAL FACTORS DRIVING HEALTH PLAN WITHDRAWALS FROM MEDICARE+CHOICE v (2001), at <http://www.cmwf.org>. Enrollment has declined substantially since that point in time as health plans have terminated their contracts and reduced their service areas. Cooper, *supra* note 55, at 24 (indicating enrollment has dropped from 16% in 1999 to 11% in 2003).

⁵⁷ Pub. L. No. 108-173, 117 Stat. 2066 (2003).

⁵⁸ Jacksonis, *supra* note 49, at 230.

⁵⁹ Stuart M. Butler and Robert E. Moffit, *Medicare Analysis: The FEHBP as a Model for a New Medicare Program*, HEALTH AFFAIRS (Winter 1995).

⁶⁰ OFFICE OF PERSONNEL MANAGEMENT, FEHBP HANDBOOK (Aug. 22, 2003), at <http://www.opm.gov/insure/handbook/fehb00.asp>.

⁶¹ *Purchasing Health Care Services in a Competitive Environment: Hearing Before the Senate Comm. on Finance*, 108th Cong. 1 (2003) (statement of Abby L. Block, Senior Advisor for Employee and Family Policy, Office of Personnel Management), at <http://finance.senate.gov/sitemaps/hearing040303.htm> (emphasis added) [hereinafter *Senate Finance Hearing*].

⁶² Mark A. Hall, *supra* note 4.

⁶³ “Empirical research on the design of health insurance plans has shown that people who face few out-of-pocket costs tend to use more medical care than those who pay even modest copayments for their care.” CONG. BUDGET

All FEHBP plans “offer a core set of benefits broadly outlined in statute,” but “benefits vary among plans because there is no standard benefits package.”⁶⁴ This structure provides plans with broad flexibility, encourages innovation and thereby capitalizes on private sector initiatives.⁶⁵ In many ways a comparison of Medicare and FEHBP highlight the contrasting characteristics of heavy regulation versus deregulation/free market principles and egalitarianism versus consumerism.

As the Department of Defense sought to transition to managed care, the FEHBP, which possessed roughly the same number of beneficiaries as the military health care system, provided a successful, universally recognized model in the form of a relatively passive federal purchaser of employee health care. Nonetheless, the Department of Defense rejected this model in the establishment of TRICARE, instead staking out a different, customized pathway for itself.

B. The Origins of TRICARE – Major Demonstration Projects

In the mid-1980s, as a result of dramatic increases in CHAMPUS costs, the Department of Defense and Congress sought to explore ways of redesigning the military health care system to make it more efficient.⁶⁶ Congress provided the Secretary of Defense with Title 10 authority to “conduct studies and demonstration projects on the health care delivery system of the uniformed services with a view to improving the quality, efficiency, convenience, and cost-effectiveness of providing health care services.”⁶⁷ Consequently, as civilian employers and the nation as a whole were exploring ways to curb rising health care costs, the military was also tasked with exploring

OFFICE, *supra* note 6, at 16. See also JEANNE S. RINGEL ET. AL, RAND CORP, THE ELASTICITY OF DEMAND FOR HEALTH CARE – A REVIEW OF THE LITERATURE AND ITS APPLICATION TO THE MILITARY HEALTH SYSTEM (2002), available at <http://www.rand.org/publications/MR/MR1355/MR1355.pdf>.

⁶⁴ *Senate Finance Hearing*, *supra* note 61, at 2 (statement of Abby L. Block, Senior Advisor for Employee and Family Policy, Office of Personnel Management) (“While the program has a statutory and regulatory framework, key aspects of plan design, such as coverage or exclusion of certain services and benefit levels are in neither law nor regulation”).

⁶⁵ *Id.* at 3.

⁶⁶ H.R. REP. NO. 99-718, at 237 (1986).

⁶⁷ 10 U.S.C. § 1092(a)(1) (2004) (added by Pub. L. No. 98-94, §933(a)(1), 97 Stat. 650 (1983)).

alternative methods of payment for health care services,⁶⁸ beneficiary cost-sharing,⁶⁹ innovative approaches to delivery and financing of health care⁷⁰ and prepayment for services.⁷¹

1986 proved to be a significant year in the history of military health care as what were considered to be major improvements and reforms were contemplated and statutory authority enacted. Three significant revisions were addressed during the annual national defense authorization act cycle for fiscal year 1987: the need for better integration of direct and purchased care, the establishment of a health care enrollment system, and an initiative to reform the CHAMPUS fee-for-service system into a hybrid system of managed care.⁷²

The first effort sought to better integrate the Department's direct care system with CHAMPUS. Up until this point in time, with the exception of requiring some beneficiaries to obtain authorization prior to nonemergency inpatient hospitalization outside the direct care system,⁷³ beneficiaries were free to choose between direct and fee-for-service care and to move back and forth between the two.⁷⁴ Additionally, because the two systems were fragmented when it came to budgeting,⁷⁵ there was no accountability for the military treatment facilities to maximize direct care in favor of the more expensive CHAMPUS care, even when nonavailability statements were required.⁷⁶ As a result, CHAMPUS claims surged and the Department

⁶⁸ 10 U.S.C. § 1092(a)(1)(A) (2004).

⁶⁹ 10 U.S.C. § 1092(a)(1)(B) (2004).

⁷⁰ 10 U.S.C. § 1092(a)(1)(D) (2004). Across the nation, reform efforts in both the public and private sectors were focused on some form of integration between the financing and provision of health care. Sara Rosenbaum and Brian Kamoie, *Managed Care and Public Health: Conflict and Collaboration*, 30 J.L. MED. & ETHICS 191, 192 (2000); Weiner & Lissovov, *supra* note 9, at 85-86.

⁷¹ 10 U.S.C. § 1092(a)(1)(F) (2004).

⁷² H.R. REP. NO. 99-718, at 237-243 (1986).

⁷³ Authorization consisted of nonavailability statements, indicating the requested medical services were not available within the direct care system, either due to lack of space available, resources or required expertise.

⁷⁴ See H.R. REP. NO. 99-718, at 246 (1986).

⁷⁵ CHAMPUS payments were financed centrally through the Department of Defense while the military services individually financed the operation and maintenance of their own military treatment facilities.

⁷⁶ As the House Armed Services Committee observed, "Why should the services try to use military treatment facilities more fully, thereby absorbing more expensive CHAMPUS workload, when they are not accountable for those CHAMPUS dollars? Indeed, the present budgetary set-up encourages the services to shift patients out of

experienced significant budget shortfalls.⁷⁷ Through the creation of a Military Health Care Account, Congress sought to make the first step towards integrating direct and purchased care through financing.⁷⁸ Through this new account, the Secretary of Defense would allot to each service funding believed necessary to meet their CHAMPUS expenses.

Using their operation and maintenance appropriation for the direct care system and their allotment from the transfer account, the services would be responsible for providing all medical care to their beneficiary population [including CHAMPUS costs] and would have to seek to reprogram funds appropriated for other programs to make up any shortfall.⁷⁹

The significance of this was not so much in the specific nature of the revision pursued, as this has subsequently changed, as it was the recognition of the inherent flaw in the system's current structure and questionable incentives. Specifically, the lack of integrated funding between direct and purchased care, frequently resulted in a less than optimal utilization of direct care capacity at the expense of purchased care. Failure to incrementally increase funding for the arguably underfinanced and understaffed direct care system in order to maximize direct care capacity, resulted in an exponential increase in purchased care expenses to the overall detriment to the defense health program.⁸⁰

direct care, with little regard for CHAMPUS expenses." H.R. REP. NO. 99-718, at 238. In essence, military treatment facilities were free to engage in adverse selection and had no incentive to provide less costly care by contracting for additional staff in military hospitals, since any such effort would impact the facilities' budgets but referral to the more costly CHAMPUS would not.

⁷⁷ *Id.* (citing a 19% increase in CHAMPUS claims for inpatient care within the military hospital catchment area [roughly a 40-mile radius] in the first half of fiscal year 1986 alone while CHAMPUS claims outside the catchment area remained stable).

⁷⁸ National Defense Authorization Act for Fiscal Year 1987, Pub. L. No. 99-661, 100 Stat. 3816, 3896-97 (codified at 10 U.S.C. § 1100) (1986) (10 U.S.C. § 1100 has been significantly amended subsequently). *See also* H.R. REP. NO. 99-718, at 239 ("This situation will only change if the services program funds for direct care and CHAMPUS in unison.").

⁷⁹ H.R. REP. 99-1001, at 488 (1986).

⁸⁰ *See, e.g.*, GEN. ACCOUNTING OFFICE, GAO/HRD-90-131, DEFENSE HEALTH CARE: POTENTIAL FOR SAVINGS BY TREATING CHAMPUS PATIENTS IN MILITARY HOSPITALS – REPORT TO THE CHAIRMAN, SUBCOM. ON MILITARY PERSONNEL AND COMPENSATION, HOUSE COMM. ON ARMED SERVICES (1990), *at* <http://www.gao.gov> (retrievable by Report # GAO/HRD-90-131) (discussing the potential savings from adding staff and other resources to military treatment facilities in order to treat more patients with direct rather than purchased care).

A second major flaw in the current system structure was the inability to accurately define the beneficiary population.⁸¹ This flaw was a clear impediment to the more efficient provision of medical services in both the direct and purchased care systems. Without this data, there was no way to accurately determine the number of covered lives and the amount of financial risk a risk bearing entity would be subjected to.⁸² As a result, legislation was enacted directing the Secretary of Defense to establish an enrollment system for health care beneficiaries.⁸³

Finally, the third and most significant system reform involved CHAMPUS. The Department of Defense fashioned a sweeping reform measure which would transition the CHAMPUS program from one of self-insurance into the realm of managed care.⁸⁴ The Department further sought to consolidate its “widely dispersed, buying power . . . to strike more favorable deals.”⁸⁵

1. CHAMPUS Reform Initiative (CRI)

a. Structure and Design

⁸¹ As the United States House of Representatives Committee on Armed Services recognized:
The Defense Department lacks adequate information on both the size and demographic characteristics of its beneficiary population. Unlike private insurers, who usually underwrite contracts on the basis of a defined beneficiary population, military treatment facilities do not know the true size of the patient population that they serve. Currently, beneficiaries flow between CHAMPUS and direct care virtually at will; the managers of both systems are unable to budget with any certainty for a specified beneficiary population due to the lack of data available. This lack of certainty creates substantial disruption for beneficiaries as well; they do not know from one visit to another, first, whether specific types of care will be available at the military hospital, and second, if available, how long the wait for that care will be. It is a no-win situation for all concerned.

H.R. REP. NO. 99-718, at 239-40 (1986).

⁸² See Weiner & Lissovoy, *supra* note 9, at 82-84 (discussing at length the role of financial risk in managed care).

⁸³ See 10 U.S.C. § 1099 (2003). Upon enactment in 1986, however, initial implementation, and thus the effective dates of various provisions in 10. U.S.C. § 1099, were phased in over a number of years. National Defense Authorization Act for Fiscal Year 1987, Pub. L. No. 99-661, § 701(d)(1) and (2), 100 Stat. 3816, 3898 (1986).

⁸⁴ H.R. REP. NO. 99-718, at 237 (1986).

⁸⁵ H.R. REP. NO. 100-58, at 219-20 (1987).

The Department of Defense first envisioned this reform, named “Project Imprint”, would “replace CHAMPUS with three regional contractors – and perhaps, ultimately with a single, nationwide contractor – who would be at financial risk for all care not provided in military medical facilities.”⁸⁶ The concept was designed to replace the Department’s fee-for-service CHAMPUS with regional contractors who would assume ultimate responsibility for providing care at a fixed cost to dependents and retirees, by utilizing a combination of military and civilian care. As in any managed care plan, beneficiaries would be offered incentives, in the form of reduced cost sharing, if they utilized the less expensive specified provider network that offered discounted services under the CHAMPUS Reform Initiative.

The Department of Defense’s objectives included: containing CHAMPUS costs, increasing access to care, improving coordination between the direct and purchased care systems, assuring quality of care, and simplifying administrative procedures.⁸⁷ In order to achieve those objectives, the Department of Defense envisioned the following:

- competitive fixed-price contracts awarded to private sector health care providers to help contain costs;
- a voluntary enrollment system, called CHAMPUS Prime, to improve beneficiary access to care and simplify CHAMPUS administrative procedures;
- a health care finder mechanism to improve coordination between CHAMPUS, military treatment facilities and beneficiaries;
- quality assurance standards that must be adhered to by contractors; and
- staff-sharing agreements whereby contractor staff would augment staff in military treatment facilities.⁸⁸

⁸⁶ H.R. REP. NO. 99-718, at 237.

⁸⁷ *CHAMPUS Reform Initiative Unresolved Issues: Hearing Before the Subcomm. on Manpower and Personnel, Senate Comm. on Armed Services, 100th Cong. (1987) (statement of David P. Baine, Director, Federal Health Care Delivery Issues, Human Resources Division, Gen. Accounting Office), 2, at* <http://www.gao.gov> (retrievable by Report # GAO/T-HRD-87-5) [hereinafter *CRI Unresolved Issues Hearing*].

⁸⁸ *Id.* at 1.

What the Department sought was a customized managed health care program designed to both utilize and supplement the existing direct care system. The majority of care would continue to be provided through the direct care system, with the continued availability of fee-for-service CHAMPUS benefits and the option of voluntary participation in the managed-care plans. Under the managed care option, contractors would negotiate for discounted private sector care to deal with the overflow from the direct care system.

For a number of reasons, what the Department of Defense sought to create and what they eventually produced differed in both magnitude and design. First, Congress, concerned with the sheer magnitude of this transformation,⁸⁹ authorized the Department to proceed with a smaller CHAMPUS Reform Initiative (CRI) demonstration project to determine the feasibility of phasing in such an approach nationally.⁹⁰

Comments were then solicited from industry on the Department's draft request for proposals. General industry apprehensions included "the inability to adequately define a beneficiary population" and concerns over "adverse selection."⁹¹ Additional concerns expressed included the "excessive, overly restrictive, duplicative, and unclear" administrative requirements; "reservations about coordination of activities between the contractor and the military treatment facilities"; and that the coordination would be "difficult to achieve due to the issue of control and

⁸⁹ See H.R. REP. NO. 99-718, at 238 (1986), where the Committee on Armed Services wrote:

The goals of the CHAMPUS reform initiative are laudable. That the Department of Defense should seek the best buy on good quality medical care for its beneficiary population is obvious. But the very magnitude of the changes entailed gives the committee cause for concern . . . Does the military health care system have the expertise to write, execute, and oversee three large contracts on a nationwide basis? If the answer is anything other than unequivocally in the affirmative, the impact on beneficiaries could be detrimental. (emphasis added).

⁹⁰ National Defense Authorization Act for Fiscal Year 1987, PUB. L. NO. 99-661, § 702, 100 Stat. 3816, 3899 (1986).

⁹¹ S. REP. NO. 99-331, at 245 (1986). The fear of adverse selection in this case being the shifting of high-risk, costly patients from direct care to the contractor's responsibility under purchased care while less expensive patients remain in direct care.

the complexity of the requirements.”⁹² The Department of Defense did attempt to address “many of the concerns raised by industry respondents . . . by permitting offerors more flexibility in designing systems to meet new program features” and adjusting the risk-sharing provisions.⁹³

As the Department prepared to proceed, Congress expressed⁹⁴ additional concerns regarding the element of competition and size of the regions, recommending a smaller regional design more in line with the approach of private sector employers.⁹⁵ Notwithstanding these Congressional recommendations, the Department proceeded with plans to award separate contracts in three two-state areas: Florida and Georgia, North and South Carolina, and California and Hawaii, all areas where the direct care system was overcrowded, resulting in high CHAMPUS volume and very high costs.⁹⁶

Despite the revised request for proposals, consortia of insurance companies and managed care corporations pulled out in two of the three regions, citing “DoD’s demanding design and

⁹² *CRI Unresolved Issues Hearing*, *supra* note 87, at 7.

⁹³ *Id.* at 8. The House Armed Services Committee noted the precarious position the Department of Defense was in when it opined:

Uncertainty about costs amplifies the risks to potential bidders. The department proposes to minimize risk by offering contractors retrospective and prospective opportunities for adjusting their otherwise fixed prices. If successful from the contractors’ point of view, these adjustments may simply transfer the cost risk back to the government. If contractors still view CRI as too risky, they may submit high bids. In either case, the success of the CHAMPUS Reform Initiative hangs in jeopardy.

H. REP. NO. 100-58, at 220 (1987).

⁹⁴ Observers would now say somewhat prophetically.

⁹⁵ In the words of the House Armed Services Committee:

Competition is supposed to be an essential element of the CHAMPUS Reform Initiative. The committee is concerned that this may not be the case, however. Although the size of the current two-state regions is better than the department originally proposed – namely, dividing the country into thirds – these are still very large areas . . . Only a limited number of contractors have the capability to cover such a large area; quality of care could be jeopardized. In addition, many firms may be unwilling to assume risks for a multi-state area . . . Considerable concern also exists that only one bidder may have the capability to provide care in a two-state region . . . By contrast, employers in the private sector tend to contract on a much smaller basis – with the local Blue Cross-Blue Shield Plan or an area health maintenance organization or a city-wide network of providers. In the interest of furthering competition, the committee, therefore, recommends the issuance of a new solicitation for Phase I of CRI that reconfigures the contracts to smaller areas.

H. REP. NO. 100-58, at 222 (1987).

⁹⁶ *CRI Unresolved Issues Hearing*, *supra* note 87, at 2.

performance requirements coupled with a fixed-price contract.”⁹⁷ Only one bidder believed the risk could be manageable and submitted the lone bid in response to the Department’s request for proposals.⁹⁸ Additionally, prior to contract award for the California/Hawaii area, extensive negotiations, “focused on lowering the risk to the contractor through complex formulas that provided for sharing both potential profits and losses,”⁹⁹ were required with the bidder, Foundation Healthcare Corporation, a first-time contractor with the Department of Defense. The complex risk-sharing formula capped the contractor’s cumulative loss at less than one percent of one year’s bid price.¹⁰⁰ With such a small risk corridor, the contract resembled that of a third-party administrator and was virtually an administrative services only (ASO) vice risk contract. While no longer a “truly capitated contract”, the parties nonetheless believed that the risk-sharing provisions would provide many of the same incentives.¹⁰¹

b. CRI Implementation – Panacea or Pandemonium?

Foundation Health Corporation was provided with a six-month development phase prior to implementing a comprehensive system of health care delivery services for all eligible CHAMPUS beneficiaries in this two state, geographically separated region in August of 1988 - nothing short of a colossal undertaking.¹⁰² Foundation quickly developed a network of established sub-contractors.¹⁰³ Despite the fact that the subcontractors’ existing networks and

⁹⁷ ANDERSON, *supra* note 14, at 6.

⁹⁸ *Implementation of the CHAMPUS Reform Initiative: Hearing Before the Subcomm. on Manpower and Personnel, Senate Comm. on Armed Services*, 101st Cong. (1989) (statement of David P. Baine, Director, Federal Health Care Delivery Issues, Human Resources Division, Gen. Accounting Office), 2, at <http://www.gao.gov> (retrievable by Report # T-HRD-89-25) [hereinafter *CRI Implementation Hearing*].

⁹⁹ ANDERSON, *supra* note 14, at 7. See *id.* at 8-9 for a detailed description of the risk-sharing arrangements.

¹⁰⁰ *Id.* at 9.

¹⁰¹ *Id.*

¹⁰² *Id.* at 1.

¹⁰³ Subcontractors included:

- Foundation Health Plan, a subsidiary, which operated a series of independent practice associations (IPAs) primarily in western states. Foundation Health Plan was to manage the CHAMPUS Program for Northern California.

experience could be used as building blocks, significant customization was still required including expanding networks into areas not previously covered, incorporating the military's fixed internal delivery system into the provider network, catering to a highly mobile user population, and learning to work with a self-insuring entity that had always done business in a command and control way rather than the unregulated market in which managed care companies were used to operating. The establishment and maintenance of provider networks proved challenging in the initial years of CRI implementation in Hawaii and California.¹⁰⁴

A total of three options were provided to beneficiaries. In addition to the standard CHAMPUS fee for service option, beneficiaries were also offered CHAMPUS Prime, an enrolled program where beneficiaries would receive all civilian-provided care through a contractor-established provider network at little cost, and CHAMPUS Extra, which simply offered beneficiaries, whether or not enrolled, the option of obtaining reduced cost care through the contractor network.¹⁰⁵

In order to support these plan options, the contractor and subcontractors were required to assemble groups of physicians, other providers and hospitals who would agree to treat beneficiaries at a reduced fee and comply with the Department of Defense's contract requirements including direct claims submissions on behalf of patients and submitting to medical

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- Partners Health Plan, which developed and managed HMOs, PPOs, and other health care products, would manage the program for Southern California.
 - Queen's Health Plan, a nonprofit corporation owned by a medical center and other providers in Hawaii, was the subcontractor for that state.
 - Blue Cross of Washington and Alaska was the subcontract fiscal intermediary to process standard CHAMPUS claims. Foundation was responsible for processing claims under the new managed-care options.

Id. at 7.

¹⁰⁴ *Id.* at 16-17.

¹⁰⁵ *Potential Expansion of the CHAMPUS Reform Initiative: Hearing Before the Subcomm. on Military Personnel and Compensation, House Comm. on Armed Services*, 101st Cong., 3-4 (1990) (statement of David P. Baine, Director, Federal Health Care Delivery Issues, Human Resources Division, Gen. Accounting Office), at <http://www.gao.gov> (retrievable by Report #GAO/T-HRD-90-17).

practice and credential review.¹⁰⁶ Foundation and its subcontractors used a variety of strategies in their initial network development. Building on their preexisting commercial networks, they sought to recruit additional providers through joint ventures they had previously established and they utilized prior CHAMPUS claims data from Blue Cross where available to target providers who filed the largest number of claims.¹⁰⁷

Almost one year after implementation, Congress characterized the project as one “fraught with administrative and financial problems” and cautioned the Department of Defense to carefully consider whether to exercise the remaining options on the contract.¹⁰⁸ When examined through the lens of managed care reform, many of the problems that were experienced during the implementation of the CRI could have been, and in fact to some degree were predictable. The geneses for these problems can be subdivided into several interrelated categories – the degree of customization demanded, and the lack of experience in this sort of venture, both on the part of the contractor and the Department, further compounded by a short implementation period.

Most notably, despite the Department’s goal of obtaining regional risk bearing entities, minimal interest was expressed and reduced risk sharing on the part of the contractor was necessitated by both the customized nature of the system and lack of good data on the beneficiary population. Contractor inexperience with the military also led to problems. During the initial contract term, the Department of Defense “expressed frustration over Foundation’s lack of responsiveness to demands for contract compliance.”¹⁰⁹ Furthermore, concerns over the financial condition of Foundation required contract modification to incorporate additional safeguards in the form of segregated escrow accounts and Department approval for fund release

¹⁰⁶ ANDERSON, *supra* note 14, at 14.

¹⁰⁷ *Id.* at 15-16.

¹⁰⁸ H.R. REP. NO. 101-121, at 302-03 (1989).

¹⁰⁹ *CRI Implementation Hearing*, *supra* note 98, at 8.

to ensure protection of government funds.¹¹⁰

Moreover, the contractor experienced some problems in developing and maintaining the network – some challenges attributable to managed care in general compounded exponentially by the unique design and requirements of the Department of Defense, coupled with an inadequate implementation period. For example, in two-thirds of the military treatment facility services areas, Prime was not available until nine months after the implementation phase was to have concluded.¹¹¹ Additionally, some providers refused to join the network when they discovered Foundation was obligated to maximize the use of military treatment facilities first and that Foundation would not be working directly for the provider.¹¹² There were gaps in coverage as well as Foundation struggled to acquire providers in certain remote areas.¹¹³ The contractors also experienced significant erosion of their preexisting networks as providers withdrew due to the lower fee schedule and dissatisfaction with the military managed care program, particularly claims processing.¹¹⁴

Claims processing quickly became the Achilles heel of the system, and threatened the very continuation of the government contract.¹¹⁵ Claims processing, enrollment and beneficiary tracking proved to be too much for Foundation's computer system.¹¹⁶ Less than ten months into the contract, Foundation had over 214,000 unprocessed claims, seventy percent of which

¹¹⁰ See H.R. REP. NO. 101-121, at 302-03 (1989); *CRI Implementation Hearing*, *supra* note 98, at 11-12.

¹¹¹ RAND CORP., RB-4526, RESEARCH HIGHLIGHTS: INTRODUCING MANAGED CARE IN THE MILITARY HEALTH SYSTEM 3 (1999), *at* <http://www.rand.org/publications/RB/RB4526/> [hereinafter RESEARCH HIGHLIGHTS].

¹¹² ANDERSON, *supra* note 14, at 16.

¹¹³ *Id.* at 17.

¹¹⁴ *Id.* at 16-17.

¹¹⁵ *CRI Implementation Hearing*, *supra* note 98, at 8 (quoting a DoD site visit report "the Foundation Health Corporation's MIS [management information system] support to CRI operations and management [is] deficient in every aspect and at every organizational level . . . unsatisfactory performance in MIS jeopardizes continuation of the entire project"). *See also* H.R. REP. NO. 101-121, at 303 (1989).

¹¹⁶ ANDERSON, *supra* note 14, at 25.

exceeded the contract requirement that all claims be processed within thirty days.¹¹⁷ Problems escalated with both beneficiaries and providers to the point that Foundation started paying providers seventy percent of their historical CHAMPUS-charged bills and then began an automatic payment program for all providers where any claim over thirty days old received a preliminary payment of seventy to seventy five percent of the actual charges.¹¹⁸ These unitemized payments further frustrated providers as bookkeeping became impossible.¹¹⁹ Collection actions were also initiated against beneficiaries, much to their dissatisfaction and dismay.¹²⁰ The negative impact that resulted from the failures in claims processing were felt throughout every aspect of CRI, as resources were redirected to try and solve this problem at the expense of other goals and conflicting priorities.¹²¹

Some beneficiaries also expressed concern over a perceived erosion of benefits and found the new program's protocols confusing.¹²² A number of these concerns can be attributed to the introduction of managed care principles in general.¹²³ Others were attributable to the rapid implementation period and the difficulty in educating such a fluid beneficiary population. These initial experiences certainly demonstrate that the Department of Defense's goal of administrative simplification and increased beneficiary satisfaction were illusory during the implementation phase of the initiative. Additionally, despite the goal of administration simplification, it was

¹¹⁷ *CRI Implementation Hearing*, *supra* note 98, at 6.

¹¹⁸ ANDERSON, *supra* note 14, at 32.

¹¹⁹ *Id.* at 32-33.

¹²⁰ *Id.* at 32.

¹²¹ For example, additional full-time staff had to be hired to augment claims work and provider and beneficiary relations in order to handle the large number of complaints. Marketing staffs were diverted to assist. Utilization review suffered as enforcement was reduced in an effort to prevent further aggravation and loss of providers. ANDERSON, *supra* note 14, at 33.

¹²² *Id.* at 23.

¹²³ These concerns would include a loss of choice in providers and the restrictions of tightly managed care. See generally Alain C. Enthoven et al., *Consumer Choice and the Managed Care Backlash*, 27 AM. J.L. & MED. 1 (2001); Marc A. Rodwin, *Backlash as Prelude to Managing Managed Care*, 24 J. HEALTH POL. POL'Y & L. 1115 (1999).

clear from the start that program complexity would in fact increase.¹²⁴ Furthermore, an independent evaluation mandated by Congress revealed that the CHAMPUS Reform Initiative actually resulted in an eight percent increase in costs to the government.¹²⁵

Despite the problems, the parties were able to glean certain valuable lessons.¹²⁶ Clearly, both the contractor and the government underestimated the complexity of the undertaking as well as the time it would take. Had the implementation period been extended, some of these problems could have been avoided, or at least minimized. Other problems were inevitable and continue to challenge the Department of Defense.¹²⁷

2. Catchment Area Management (CAM) Initiative

Concurrently with CRI, a second major alternative health care delivery system was conceptualized and implemented.¹²⁸ The program, called Catchment Area Management (CAM), sought to systematically address such questions as "Is 'massive buying power' really necessary to strike favorable deals with the private sector? Are local medical commanders truly unable to acquire and manage complex new capabilities? Indeed, what is the best level at which to manage the military health care system?"¹²⁹ In contrast to the CHAMPUS Reform Initiative, under the CAM initiative primary authority rested at the military treatment facility commander level vice a regional contractor. Individual military treatment facility commanders would be responsible for

¹²⁴ See GEN. ACCOUNTING OFFICE, GAO/HRD-87-65BR, DEFENSE HEALTH CARE: CHAMPUS REFORM INITIATIVE: UNRESOLVED ISSUES – BRIEFING REPORT TO CONGRESSIONAL REQUESTERS 17-19 (1987).

¹²⁵ RESEARCH HIGHLIGHTS, *supra* note 111 (opining that implementation problems may have "hampered its ability to control costs").

¹²⁶ *Id.* at 3 (citing increased access to care and satisfaction among enrolled beneficiaries once fully operational). See also ANDERSON, *supra* note 14, at 59:

A military managed-care program like CRI is extraordinarily complex because it must coordinate the military and civilian health care systems and accommodate a mobile beneficiary population... . Creating satisfactory working relationships among organizations with differing perspectives requires considerable effort to establish communication channels, educate all groups about the managed-care program, and train staff in the program and the context for its implementation.

¹²⁷ Ongoing challenges include claims processing and network adequacy.

¹²⁸ National Defense Authorization Act for Fiscal Years 1988 and 1989, Pub. L. No. 100-180, § 731, 101 Stat. 1019, 1117 (1987).

¹²⁹ H. REP. NO. 100-58, at 222-23 (1987).

providing all beneficiary care in their catchment areas, by providing care in their own facilities or through other alternative arrangements they would establish.¹³⁰ Commanders would have the ability to choose “any type of health care delivery system, for any scope of coverage” they determined appropriate.¹³¹ By allowing local commanders, on a smaller geographic scale, the flexibility to acquire and modify resources as needs dictate, this demonstration project is arguably much more in line with the practices of the private sector. The goals of CAM mirrored those of CRI - constrain the growth of CHAMPUS costs and improve beneficiary satisfaction with the military healthcare system. The localization of choice approach taken under CAM however, was a mirror image of the CRI philosophy of big block purchasing from private companies.

3. Other Efforts to Reduce Costs and Provide Efficiencies

In addition to planning for a national transition to managed care, the Department of Defense also enlisted other methods to assist in reducing medical expenditures. For example, the military purchased care system was paying on average fifty percent higher physician reimbursement rates than Medicare.¹³² In 1991, the Department of Defense began reducing the maximum allowable charges for civilian physicians down to Medicare levels.¹³³ The Department of Defense is now statutorily required, with some permissible exceptions in remote areas and to ensure adequate numbers and mixes of qualified network physicians, to set their maximum allowable charge rates¹³⁴ using the Medicare fee schedule.¹³⁵

¹³⁰ National Defense Authorization Act for Fiscal Years 1988 and 1989 § 731(b), 101 Stat. at 1117; H. REP. NO. 100-58, at 223 (1987).

¹³¹ National Defense Authorization Act for Fiscal Years 1988 and 1989 § 731(b).

¹³² GEN. ACCOUNTING OFFICE, REPORT TO CONGRESS GAO-01-620, ACROSS-THE-BOARD PHYSICIAN RATE INCREASE WOULD BE COSTLY AND UNNECESSARY 1 (2001), at <http://www.gao.gov> (retrievable by Report #GAO-01-620) [hereinafter ACROSS-THE-BOARD PHYSICIAN RATE INCREASE].

¹³³ Department of Defense Appropriations Act, 1991, Pub. L. No. 101-511, § 8012 (1990). Rate reductions were capped at a 15% per year. *Id.*

¹³⁴ Referred to as the CHAMPUS maximum allowable charge (CMAC).

The transition to managed care contracts necessitated changes in the way direct care facilities were operating as well.¹³⁶ Military treatment facilities were forced to undergo a shift in priorities in order to accommodate managed care's primary goal – cost avoidance.¹³⁷ In an effort to better mirror civilian practices and capture the financial incentives of managed care, resource allocation methods were put into place to serve as the primary criteria for allocation of resources to the military treatment facilities.¹³⁸ The blending of direct and purchased care proved to be challenging as well as the Department of Defense, individual military services, military treatment facility commanders, and contractors has to sort through a variety of command and control issues.

The CRI and CAM demonstration projects and above-mentioned efforts to achieve greater cost efficiency are by no means exhaustive. Rather, they are meant to illustrate the breadth of the spectrum of options available to the Department of Defense as they sought to develop a national managed care plan.

¹³⁵ National Defense Authorization Act for Fiscal Year 1996, Pub. L. No. 104-106, § 731, 110 Stat. 186 (1986) (codifying what had previously been annual Department of Defense Appropriations Act provisions at 10 U.S.C. § 1079(h)).

¹³⁶ Richard K. Bachman, *Turning an Organization on its Head (Military Medical Management)*, 22 PHYSICIAN EXECUTIVE 25 (1996), *at* 1996 WL 9253174:

Military hospitals are becoming partners in an integrated system as the Department of Defense's nationwide managed care contract, TRICARE, is implemented. They are discovering they need to be competitive. No longer protected by a steady, reliable funding source, they must demonstrate relevance in order to survive. This realization has caused a paradigm shift in military medicine, generating new strategies in management and operations.

¹³⁷ Not that such a shift was unique. As managed care principles have taken hold, providers across the country have had to face a shift in financial incentives from one of providing more care to one of providing less care, while still satisfying their professional obligations. *Pegram v. Herdrich*, 520 U.S. 211, 218-219 (2000). The experience was no different for the military as military treatment facilities were faced with these issues for the first time during the implementation of the CHAMPUS Reform Initiative:

Individuals . . . should recognize that military clinicians and administrators have not previously had an incentive to reduce costs. Their priorities, aside from an individually rewarding medical practice, are access to high-quality medical care for military beneficiaries and the maintenance of medical training programs. Proponents of managed care hold that it enhances quality and access and can provide a better mix of patients for medical training, but this is not immediately clear to the MTF's medical states. Early attention must be given to convincing them that cost avoidance does not mean low-quality medicine, reduced access to medical care, or degraded training.

ANDERSON, *supra* note 14, *at* 60.

¹³⁸ 10 U.S.C. §1101 (2004).

Regardless of the demonstration project and method for capturing some of the benefits of managed care, some basic problems still needed to be fixed within the military health care system. First, the military still lacked a comprehensive enrollment system which would be essential to both gather beneficiary data and to predict future levels of required services.¹³⁹ They also still lacked a budgeting and resource allocation system that could “accurately predict resource needs, distribute resources equitably, and give managers the proper incentives to achieve the desired health care and budgetary objectives.”¹⁴⁰ Simultaneously, the military was struggling with how to control costs and utilization of services through the use of appropriate incentives, and whether those incentives should resemble carrots or sticks.¹⁴¹ Finally, while arguably experienced in government procurement contracting in general, the Department of Defense was faced with the daunting and somewhat unfamiliar task of contracting for civilian health care services,¹⁴² during an aggressive period of health reform across the nation no less.

Both civilian managed-care programs and the military health care system are complex operations. Merging them requires detailed planning, personnel with appropriate skills and training, the cooperation and support of all facets of the [military health care system], education of those charged with carrying out the new program, and time for them to test and adjust the processes and procedures of the numerous components. *Short cuts in any of these areas may prove counterproductive to intended goals.*¹⁴³

C. TRICARE

As employers and the nation as a whole faced rapidly escalating health care costs, the military confronted even greater challenges:

¹³⁹ H.R. REP. NO. 101-121, at 301 (1989) (chastising the Department for their slow progress in meeting the requirement to phase in a health care enrollment system).

¹⁴⁰ *Obstacles in Implementing Coordinated Care : Hearing Before the Subcomm. on Military Personnel and Compensation, House Comm. on Armed Services*, 102nd Cong. (1992) (statement of David P. Baine, Director of Federal Health Care Delivery Issues, Human Resources Division, Gen. Accounting Office), 6, at <http://www.gao.gov> (retrievable by Report # T-HRD-92-24) [hereinafter *Obstacles Hearing*].

¹⁴¹ *Id.* at 2-4.

¹⁴² *Id.* at 7 (suggesting a number of factors that should be considered in determining how to maximize the direct care system and contract out where it makes the most economic sense).

¹⁴³ ANDERSON, *supra* note 14, at vi (emphasis added).

The downsizing of the military structure and the growing demand for care from nonactive-duty beneficiaries was concurrent with significant growth in health care costs. Between 1980 and 1990, DoD health care costs grew by almost 225 percent, compared to about a 166 percent increase in national health expenditures. During this period, the medical portion of the Defense budget doubled, from 3 percent of the total to 6 percent.¹⁴⁴

Despite the variety of demonstration projects and other cost-containment initiatives the Department of Defense sought to incorporate in the late 1980s, health care costs continued to escalate rapidly under CHAMPUS.¹⁴⁵ As a result, the Department of Defense developed a plan in the early 1990s to implement a nationwide transformation of the military health care system to one of managed care, utilizing a combination of features from the two main demonstration projects.¹⁴⁶ Some went so far as to suggest that the Department of Defense's transition to managed care could provide useful information to both public and private sectors:

As the country moves toward national health care reform, DoD should be in a position to not only adopt the main principles embodied in the so called managed competition model but, based on its experiences thus far, it should be able to provide useful information and assistance to others, both in the public and private sectors, in implementing the program.¹⁴⁷

While the TRICARE program definition was not formally incorporated into Title 10 of the United States Code until 1997,¹⁴⁸ the necessary basic statutory contracting authority was enacted in 1986, and remains largely unchanged today.¹⁴⁹ This statutory contracting authority is quite broad in both the scope of health care services to be contracted and the range of entities with

¹⁴⁴ *Observations on Proposed Benefit Expansion Hearing*, *supra* note 39, at 4.

¹⁴⁵ GEN. ACCOUNTING OFFICE, B-245832, DEFENSE HEALTH CARE: IMPLEMENTING COORDINATED CARE – A STATUS REPORT 1 (1991) (CHAMPUS costs alone increased “from \$1.4 billion in fiscal year 1985 to an estimated \$3.6 billion in fiscal year 1991”).

¹⁴⁶ *Id.* at 1-2.

¹⁴⁷ *Lessons Learned from DoD’s Managed Health Care Initiatives : Hearing Before the Subcomm. on Military Forces and Personnel, House Comm. on Armed Services*, 103rd Cong. (1993) (statement of David P. Baine, Director, Federal Health Care Delivery Issues, Human Resources Division, Gen. Accounting Office), 5, at <http://www.gao.gov> (retrievable by GAO Report # T-HRD-93-21).

¹⁴⁸ 10 U.S.C. § 1072(7) (2004).

¹⁴⁹ National Defense Authorization Act for Fiscal Year 1987, Pub. L. No. 99-661, §701(a)(1), 100 Stat. 3895 (1986) (codified at 10. U.S.C. §1097).

which the Secretary may enter into contracts, including HMOs, PPOs, individual providers, medical facilities, and insurers to consortiums of such providers, facilities and insurers.¹⁵⁰

The development of coordinated care, eventually renamed TRICARE, consumed several years, and resulted in a significant amount of Congressional and Government Accounting Office oversight. Challenges and concerns over how to proceed included the lack of a consensus on the appropriate incentives to use in the system, whether carrots or sticks; the need to make key operational decisions in the face of little data; the best method to approach budget and resource allocation decisions; how to address continuing budget constraints; and the method and scope of contracting for health services.¹⁵¹

1. Congressional Mandates on the Design of Military Managed Care

Under continued close Congressional scrutiny, several additional legislative requirements were imposed in 1993, as the Department continued to shape its nation-wide plan. First, the Department of Defense was directed to develop an HMO health benefit option, modeled on both private sector and other similar government health insurance programs, which would then be included as one of the options in all future managed health care initiatives.¹⁵² Furthermore, the costs of this new HMO option were required to be no greater than the costs that would otherwise be incurred under a traditional CHAMPUS fee-for-service structure.¹⁵³ During the same legislative cycle, as part of the annual Defense Appropriations Act, the Department of Defense was required to establish a triple option health benefit plan.¹⁵⁴ The nation-wide managed health care program was required to include:

¹⁵⁰ 10 U.S.C. §1097(a) and (b) (2004).

¹⁵¹ *Obstacles Hearing, supra* note 140.

¹⁵² National Defense Authorization Act for Fiscal Year 1994, Pub. L. No. 103-160, § 731(a) (1993).

¹⁵³ National Defense Authorization Act for Fiscal Year 1994, Pub. L. No. 103-160, § 731(c) (1993).

¹⁵⁴ Department of Defense Appropriations Act, 1994, Pub. L. No. 103-139, §8025, 107 Stat. 1418, 1443 (1993).

- (1) a uniform, stabilized benefit structure characterized by a triple option health benefit feature;
- (2) a regionally-based health care management system;
- (3) cost minimization incentives including “gatekeeping” and annual enrollment procedures, capitation budgeting, and at-risk managed care support contracts; and
- (4) full and open competition for all managed care contracts.¹⁵⁵

They were directed to implement this nation-wide system by September 30, 1996.¹⁵⁶

2. Implementation and Growth of TRICARE – The Successes and Challenges that Have Arisen

In accordance with Congressional mandates, TRICARE provides a triple option benefit program to beneficiaries:¹⁵⁷

- **TRICARE Prime:** a tightly managed HMO-like plan requiring beneficiary enrollment and providing coordination of care through a primary care manager. Prime care is provided through a combination of direct care resources and contractor-provider civilian services as required. Enrollees may also seek care from non-network providers through a point-of-service (POS) option. Active-duty military are automatically enrolled in TRICARE Prime and other beneficiaries are given the option.
- **TRICARE Standard:** the traditional indemnity fee-for-service (FFS) benefit, formerly CHAMPUS. No enrollment is required.
- **TRICARE Extra:** provides beneficiaries with the option of enjoying reduced cost sharing through the use of preferred civilian network providers (PPO) on a case-by-case basis. No enrollment is required.

In addition to this triple option benefit program, all beneficiaries may pursue free care from military treatment facilities on a space available basis, subject to access priority rules.¹⁵⁸ The

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ TRICARE Program, 32 C.F.R. § 199.17(a)(6)(ii) (2004).

¹⁵⁸ TRICARE Program, 32 C.F.R. § 199.17(d)(1) (2004). Access priority is generally provided in the following order: active duty service members, active duty family members enrolled in TRICARE Prime, retirees and their family members enrolled in TRICARE Prime, active duty family members not enrolled in TRICARE Prime, and all other eligible persons. *Id.*

result is an integrated system that serves two distinct, yet interrelated missions and provides each beneficiary with a blending of direct and purchased care.

a. Contract Award

The national TRICARE implementation plan consisted of awarding a total of seven contracts covering twelve regions.¹⁵⁹ These contracts were competitively bid by region beginning in 1994 and proved to be much more difficult and time-consuming than anticipated.¹⁶⁰ These difficulties, coupled with the need for adequate preparation,¹⁶¹ necessitated an extension of the Congressional deadline for nationwide implementation to September 30, 1997.¹⁶² Not surprisingly, some questioned whether the Department of Defense had the necessary technical expertise to evaluate offerors' proposals.¹⁶³ Those concerns were not unfounded as all seven contract awards were protested by losing bidders, and three of the seven protests were sustained by the General Accounting Office, requiring them to be re-bid.¹⁶⁴ The initial contracts were labeled as fixed-price, at risk contracts, however the contractors' risks were significantly limited and adjustments

¹⁵⁹ For a map of the regions, see <http://www.tricare.osd.mil>.

¹⁶⁰ *DoD's Managed Care Program Continues to Face Challenges : Hearing Before the Subcomm. on Military Personnel, House Comm. on National Security*, 103rd Cong. (1995) (statement of David P. Baine, Director, Federal Health Care Delivery Issues, Health, Education, and Human Services Division, Gen. Accounting Office), 6, at <http://www.gao.gov> (retrievable by Report # T-HEHS-95-117) [hereinafter *DoD's Program Continues to Face Challenges*] (documenting that one regional contract took almost 2 years to award).

¹⁶¹ *Challenges Facing DoD in Implementing Nationwide Managed Care : Hearing Before the Subcomm. on Military Forces and Personnel, House Comm. on Armed Services*, 104th Cong. (1994) (statement of David P. Baine, Director, Federal Health Care Delivery Issues, Health, Education, and Human Services Division, Gen. Accounting Office), 7, at <http://www.gao.gov> (retrievable by Report # T-HEHS-94-145) [hereinafter *Challenges Facing DoD in Implementing Nationwide Managed Care*] (explaining the Congressionally mandated timeline "had created a situation in which the procurement process appears to have gotten ahead of some necessary planning tasks" including issuing requests for proposals from offerors before the Department's completion of regional plans which would identify unique requirements.).

¹⁶² Department of Defense Appropriations Act, 1996, Pub. L. No. 104-61, Title VI, 109 Stat. 636, 649 (1995). Accord H.R. Rep. 104-261, at 124 (1995); S. Rep. No. 104-124, at 201 (1995).

¹⁶³ *Challenges Facing DoD in Implementing Nationwide Managed Care*, *supra* note 161, at 7.

¹⁶⁴ *Lessons Learned from TRICARE Contracts and Implications for the Future: Hearing Before the Subcomm. on Military Personnel, House Comm. on Armed Services*, 107th Cong. (2001) (statement of Stephen P. Backhus, Director, Health Care – Veterans' and Military Health Care Issues, Gen. Accounting Office), 5, at <http://www.gao.gov> (retrievable by Report # GAO-01-742T) [hereinafter *Lessons Learned Hearing*].

provided for health care cost increases beyond the contractor's control.¹⁶⁵ TRICARE implementation, separate and apart from the contract awards, also proved to be difficult.¹⁶⁶

b. Initial Reactions and Challenges

*"We would not expect an undertaking of this size to proceed without some problems, and DOD has done well in overcoming early difficulties."*¹⁶⁷

Some of the challenges faced by the Department of Defense are not unique and mirror those of the nation, as health care reform took hold in the United States.¹⁶⁸ A significant portion of the

¹⁶⁵ Contractors are at risk for up to 1% of health care cost overruns and then shared any additional losses with the government until the contractor's prepledged equity is depleted. The government then assumes responsibility for any remaining losses. *Id.* at 3.

¹⁶⁶ *Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE : Hearing Before the Subcomm. on Military Personnel, House Comm. on National Security*, 105th Cong. (1998) (statement of Stephen P. Backhus, Director, Veterans' Affairs and Military Health Care Issues, Gen. Accounting Office), 3, at <http://www.gao.gov> (retrievable by Report # T-HEHS-98-100) [hereinafter *Operational Difficulties and System Uncertainties*].

¹⁶⁷ *TRICARE Progressing, but Some Cost and Performance Issues Remain : Hearing Before the Subcomm. on Military Personnel, House Comm. on National Security*, 104th Cong. (1996) (statement of Stephen P. Backhus, Associate Director, Health Care Delivery and Quality Issues, Health, Education, and Human Services Division, Gen. Accounting Office), 7, at <http://www.gao.gov> (retrievable by Report # T-HEHS-96-100) [hereinafter *TRICARE Progressing*]. See also *TRICARE Administration: Hearing Before the Subcomm. on Military Personnel, Sen. Comm. on Armed Services*, 106th Cong. (1999) (statement of William J. Meyer, Senior Vice President, Palmetto Government Benefits Administrators (Blue Cross and Blue Shield of South Carolina)).

It is important to note at the outset that every TRICARE contract has struggled in the first year, regardless of who the contractor is. There have been major problems and much unhappiness among beneficiaries, providers, and contractors on every single contract. But also without exception, they all do very well in the second and subsequent years. There are good reasons for the problematic start each experience.

¹⁶⁸ *TRICARE Program: Hearing Before Subcomm. on Military Personnel, House Comm. on National Security*, 105th Cong. (1998) (statement of Brigadier General Dan L. Locker, Lead Agent, Health Service Region 4, Department of Defense) ("Problems or perceived problems with military health care are often attributed to TRICARE, when they are really a reflection of general trends in U.S. health care or managed care."). Regional TRICARE experiences varied to some extent dependent on how dominant civilian managed care was in the region. See, e.g., Jonathan Gardner, *Growing Pains: Defense Department Finds Adapting to Managed Care Tougher than Expected*, MODERN HEALTHCARE, Oct. 6, 1997, at 49, at 1997 WL 8802818 ("[T]he Defense Department is finding that its experience with its Tricare managed-care program is in some ways a mirror of the private sector's sometimes troubled encounter with managed care.").

Managed care commentators have observed:

One needs to take account of the rapidity with which managed care has penetrated American medical care and how little time there has been to develop the information and management systems required to monitor and fine-tune processes. With changes so large and extensive, there have been opportunities for greed, fraud, and incompetence, and we have seen some of each. To simply focus on these aberrations misses the more central transformation that has occurred. This

challenges, however, resulted from TRICARE's unique design of putting "military healthcare facilities at the hub of provider networks . . . [which] has made treatment more difficult."¹⁶⁹ A majority of the prime contractors were completely new to CHAMPUS and TRICARE "and quite naturally tried to equate TRICARE to the commercial products they were accustomed to handling."¹⁷⁰ Short implementation periods made the transition all the more difficult.¹⁷¹ Both logistical and system design problems resulted in physician organizations terminating their contracts with TRICARE regional contractors.¹⁷² Timely claims processing problems were virtually universal.¹⁷³ In areas where military treatment facilities were located, doctors complained that "inherent problems with the system" and military red tape were interfering with

transformation provides a beginning framework for systems of care that are better suited than the traditional system to the realities of future constraints, changing population dynamics, and new technologies. Managed care, in some form, is here to stay, but will need continuing redirection and fine-tuning.

David Mechanic, *Judging the Midrange Policy Implications: A Balanced Framework for Change*, 24 J. HEALTH POL. POL'Y & L. 1107, 1113 (1999).

¹⁶⁹ Gardner, *supra* note 168, at 49. See also *Observations on Proposed Benefit Expansion Hearing*, *supra* note 39, at 17: "As we have reported over the years and reiterated today, the military health system continues to be plagued with operational problems which are a source of beneficiaries' and providers' discontent."

¹⁷⁰ *TRICARE Administration: Hearing Before the Subcomm. on Military Personnel, Sen. Comm. on Armed Services*, 106th Cong. (1999) (statement of William J. Meyer, Senior Vice President, Palmetto Government Benefits Administrators (Blue Cross and Blue Shield of South Carolina)).

¹⁷¹ *Id.* (commenting on Blue Cross and Blue Shield's experiences and noting "the impossible short time between contract award and implementation, underlies many if not most of the frustrations and complaints that are apparent in the first year of a contract.").

¹⁷² See, e.g., *Defense Health Programs: Hearing Before Subcomm. on Personnel, Senate Comm. on Armed Services*, 106th Cong. (1999) (statement of Joshua W. Krebs, Chief Master Sergeant, Air Force Sergeants Assoc.) ("Hardly a month goes by without a news story of another major group of health care providers leaving the TRICARE Prime network."); Rex W. Huppke, *Lawmakers Enter Tricare Dispute*, 6,300 Patients Left in Limbo, GAZETTE (Colorado Springs), Sep. 13, 1997, at A1, at 1997 WL 7461197 (reporting the dissolution of a 250 doctor network contract with TriWest in Colorado because of physician frustration in not being able to properly serve their patients, leading to concerns over liability); Earl Golz, 2 Clinics Rejecting HMO for Veterans, AUSTIN-AMERICAN STATESMAN (Texas), Dec. 19, 1997, at D1, at LEXIS, ALLNWS File (quoting the executive administrator of a regional clinic who was withdrawing from Tricare, "It's a very difficult plan to work with. . . . Their medical management and utilization management procedures are very cumbersome. Their claims payment system is slow and unresponsive." The Austin Diagnostic Clinic, which was also withdrawing from Tricare, complained about "some inflexible issues, both financial and operational, that they were unable to work out" including the requirement for specialist referrals to be sent back to the nearest military hospital and the fact that Tricare still insisted on paper claims and payments vice electronic.).

¹⁷³ See, e.g., Bill Kaczor, *Military Health Insurer Tries to Fix Problems*, FLA. TIMES-UNION, Aug. 7, 1997, at B4, at 1997 WL 11322543;

their ability to maintain consistent care for their patients.¹⁷⁴ The administrative hassles, coupled with discounted maximum allowable rates, caused some providers to become disillusioned with TRICARE.¹⁷⁵

Observers noted that the system appeared to work better in areas where there were no military bases and doctors could maintain greater control over patient treatment.¹⁷⁶ Beneficiaries have complained as well about access to care,¹⁷⁷ the loss of their physicians as they have left the TRICARE system,¹⁷⁸ and being required to bounce back and forth between military and civilian providers.¹⁷⁹ With the conversion to TRICARE, and mandate to maximize the utilization of direct care resources, retirees over the age of 65 quickly discovered there was little or no space available at military treatment facilities and hospitals to treat them - TRICARE has resulted in reduced, not improved, access.¹⁸⁰ Pressure mounted to devise some way to accommodate these

¹⁷⁴ Rex W. Huppe, *Lawmakers Enter Tricare Dispute – 6,300 Patients Left in Limbo*, GAZETTE (Colorado Springs), Sep. 13, 1997, at A1, at 1997 WL 7461197.

¹⁷⁵ Letter from Stephen P. Backhus, Director, Veterans' Affairs and Military Health Care Issues, General Accounting Office, to The Honorable Stephen E. Buyer, Chairman, Subcommittee on Military Personnel, Committee on National Security, House of Representatives 5-6 (Apr. 10, 1998), at <http://www.gao.gov> (retrievable by Report # HEHS-98-136R). See also Jonathan Gardner, *Some Docs Refusing CHAMPUS Patients*, MODERN HEALTHCARE, Dec. 11, 1995, at 34, at LEXIS, ALLNWS File (reporting that even before the conversion to TRICARE providers were increasingly refusing to accept CHAMPUS patients based on the erosion of payments due to the statutory mandate to bring CHAMPUS payments in line with Medicare. "Docs are less willing to care for military beneficiaries because they are less likely than Medicare beneficiaries to become permanent patients, and they typically are younger patients who will visit doctors less frequently.")

¹⁷⁶ E.g., Rex W. Huppke, *Lawmakers Enter Tricare Dispute, 6,300 Patients Left in Limbo*, GAZETTE (Colorado Springs), Sep. 13, 1997, at A1, at 1997 WL 7461197.

¹⁷⁷ E.g., Debra Gordon, *Some Are Losing Their Patience Getting Tricare Appointments*, VA-PILOT, April 17, 1997, at B3, at 1997 WL 6401071. See also H.R. REP. NO. 105-532, at 314 (1998) (expressing concerns about "the complaints of many beneficiaries that the transition to this managed care program is compromising the quality and availability of their health care benefit.").

¹⁷⁸ E.g., Tom Philpott, *Frustrated Retiree Reaches Managed Care's Last Straw*, GAZETTE (Colorado Springs), June 7, 1997, at News6, at 1997 WL 7455992 (chronicling the experiences of a retired Air Force colonel in Alabama who, within three months of being enticed to join Tricare Prime, lost his family doctor, endocrinologist and primary care manager); Rex W. Huppke, *Tricare: More Voices of Discontent – Meeting at Fort Carson Airs Grips with Military's Health-Care System*, GAZETTE (Colorado Springs), Nov. 23, 1997, at News1, at 1997 WL 7464933 (reporting on concerns expressed by beneficiaries over the "beleaguered Tricare system").

¹⁷⁹ See, e.g., *Defense Health Programs: Hearing Before Subcomm. on Personnel, Senate Comm. on Armed Services*, 106th Cong. (1999) (statement of Joshua W. Krebs, Chief Master Sergeant, Air Force Sergeants Assoc.).

¹⁸⁰ E.g., Nolan Walters, *Tricare Medical System is Under the Gun for Treatment of Retirees*, MACON TELEGRAPH, March 30, 1997, at A14, at 1997 WL 9543846 (quoting the Assistant Secretary of Defense for Health Issues on the need to accommodate 65 and older retirees or risk collapse of the whole Tricare system, "Beyond the issues of

Medicare eligible retirees and their beneficiaries within the Department of Defense medical care system.¹⁸¹

c. Providing a Uniform Benefit Structure

Following the diverse demonstration projects, and resultant differences in benefits between regions, TRICARE sought to provide a uniform benefit in the form of a triple option plan. With such a fluid beneficiary population resulting from frequent military moves, consistency of benefits across regions was viewed as particularly important. In addition to the challenges of maintaining a uniform benefit across the nation, the integrated nature of the military's direct and purchased care health system structure itself created another type of inequity. Visits to the direct care system were essentially free while copayments were required from beneficiaries who utilized civilian care, regardless of how they came to utilize that civilian care. Requiring beneficiaries to incrementally share in the cost of more expensive care is a basic tenet of managed care, which is intended to drive beneficiary behavior.¹⁸² Perceived inequities occur, however, when these charges are incurred in a somewhat random fashion regardless of beneficiary behavior. This created a unique inequity for TRICARE Prime beneficiaries, who were assigned to primary care providers and whose care is tightly managed. Available resources, which varied by military facility, often times drove whether patients saw military or civilian providers. Compounded with fairly frequent moves, and the need to "relearn their health care program . . . [t]hese variations in health care offering have caused confusion and inequities

fairness, equity and responsibility – and those a [sic] truly there – I think that's a stone if you pull it out, the arch collapses."); Tom Philpott, *Military Update: Most Madigan Beneficiaries Hail Tricare, but Older Retirees Unhappy*, NEWS TRIBUNE (Tacoma, WA), April 15, 1996, at B6, at 1996 WL 2984845 ("Quite honestly, the over-65 group sees this as a lockout and is very angry"); Eric Minton, *Tricare: On the Front Lines*, 11 INDEPENDENT LIVING PROVIDER 14 (1996), at LEXIS, ALLNWS File (retirees "screaming betrayal").

¹⁸¹ See, e.g., National Defense Authorization Act for Fiscal Year 1998, Pub. L. No. 105-85, § 752, 111 Stat. 1629, 1823-24 (1997).

¹⁸² Mark A. Hall, *supra* note 4, at 1.

among beneficiaries.”¹⁸³ As a result of these concerns, copayments were eliminated for active duty family members enrolled in TRICARE Prime.¹⁸⁴

d. Claims Processing

Contractors and providers complained that TRICARE’s complexity and mandated procedures impeded efficiencies in claims processing.¹⁸⁵ Claims processing practices and hence costs deviated significantly from industry norms.¹⁸⁶ Multiple reimbursement levels made claims processing all the more complicated.¹⁸⁷ Moreover, TRICARE beneficiaries account for a very small percentage of most civilian providers’ business.¹⁸⁸ Consequently, civilian providers were more prone to sacrifice TRICARE business due to their dissatisfaction over claims processing

¹⁸³ *Observations on Proposed Benefit Expansion Hearing*, *supra* note 39, at 4-5.

¹⁸⁴ National Defense Authorization Act of 2001, Pub. L. No. 106-398, § 752, 114 Stat. 1654A-194 (amending 10 U.S.C. § 1097a to include a new subsection (e)).

¹⁸⁵ *Opportunities to Reduce TRICARE Claims Processing and Other Costs: Hearing Before the Task Force on Defense and International Relations*, House Comm. on Budget, 106th Cong. (2000) (statement of Stephen P. Backhus, Director, Veterans’ Affairs and Military Health Care Issues, Gen. Accounting Office), 3, at <http://www.gao.gov> (retrievable by Report # T-HEHS-00-138) [hereinafter *Opportunities to Reduce Costs*].

¹⁸⁶ For example, in 2000:

- TRICARE claims processing costs averaged \$7.50 per claim – double the industry average and more than four times the \$1.78 Medicare claims processing cost.
- Contractors [indicated] that of the many programs they administer, including Medicare and private plans, TRICARE is the most complicated.
- Over half of TRICARE claims were manually reviewed, a rate significantly higher than the industry average of 25%.
- Claim inquiry rates were four times higher under TRICARE than Medicare.
- Less than 20% of claims were submitted electronically compared to 85% under Medicare.

Id. at 3-5.

¹⁸⁷ *TRICARE Administration: Hearing Before the Subcomm. on Military Personnel, Sen. Comm. on Armed Services*, 106th Cong. (1999) (statement of William J. Meyer, Senior Vice President, Palmetto Government Benefits Administrators (Blue Cross and Blue Shield of South Carolina)):

Under CHAMPUS, reimbursement of claims was easily understood [capped by CHAMPUS maximum allowable charges and DRGs]. Under TRICARE, reimbursement is immeasurably more complicated and very difficult to understand. Contractors are charged with negotiating the best prices possible with providers. The result is that non-network providers are paid the way they always were, but network providers can be paid in as many ways as the imagination and advanced computer systems allow. . . . These fee plans are complicated by the fact that there are different reimbursement rates for enrolled versus non-enrolled beneficiaries, in or out of network providers, authorized or unauthorized care, referred or non-referred specialist care, and treatment in or out of the Region where the patient is enrolled. Neither the providers nor the beneficiaries can figure out what the reimbursement should be for a particular service, which results in errors and misunderstandings.

¹⁸⁸ *Opportunities to Reduce Costs*, *supra* note 185, at 4 (indicating TRICARE often accounts for less than 5 percent of providers’ income).

and had little incentive to adopt procedures for electronic claims submissions.¹⁸⁹ The Department of Defense, Congress and contractors invested a substantial amount of effort to solve this problem. Legislation was also enacted to facilitate the timely processing of claims and authorized incentives for electronic processing.¹⁹⁰ Significant improvements have been made on a number of fronts.¹⁹¹ Despite the fact that the number of claims filed tripled from 2000 to 2002,¹⁹² 97% or more of claims have consistently been processed within the 30 day TRICARE goal.¹⁹³ Additionally, as of the end of fiscal year 2002, over 70% of claims are now submitted electronically.¹⁹⁴ The percentage of TRICARE participating providers filing claims on behalf of military beneficiaries now exceed civilian benchmarks for HMO and PPO plans.¹⁹⁵ Finally, while significant improvements have been made, beneficiary satisfaction with claims processing accuracy and timeliness still slightly lags the civilian benchmark.¹⁹⁶

e. Ensuring Access to Care

Beneficiary complaints over access to care and the difficulty in making appointments have continued since the inception of TRICARE.¹⁹⁷ The problems experienced can be traced to the

¹⁸⁹ *Id.* at 6. Similar difficulties were experienced under Medicare prior to the enactment of the Omnibus Budget Reconciliation Act of 1989, which required all providers, vice beneficiaries, to submit claims forms directly. See S. REP. NO. 102-113, at 189 (1991) (suggesting DoD could benefit from a similar practice).

¹⁹⁰ See 10 U.S.C. § 1095(c) (2004). See also National Defense Authorization Act for Fiscal Year 2001, Pub. L. No. 106-398, § 727, 114 Stat. 1654A-188 (mandating additional claims processing improvements); National Defense Authorization Act for Fiscal Year 2001, Pub. L. No. 106-398, § 725, 114 Stat. 1654A-187 (seeking recommendations to discourage/prevent TRICARE providers from seeking direct reimbursement from beneficiaries).

¹⁹¹ One provider indicated, “TRICARE went from being our slowest and worst payer to our fastest and best payer.” *TRICARE Program: Hearing Before the Subcomm. on Military Personnel, House Comm. on National Security*, 105th Cong. (1998) (statement of Brigadier General Dan L. Locker, Lead Agent, Health Service Region 4, Department of Defense).

¹⁹² The number of claims filed increased from 33.9 million in 2000 to roughly 96 million in 2002. 2003 REPORT TO CONGRESS, *supra* note 10, at 23.

¹⁹³ *Id.*

¹⁹⁴ *Id.* at 24.

¹⁹⁵ *Id.* at 21.

¹⁹⁶ *Id.* at 22.

¹⁹⁷ *Defense Health Programs: Hearing Before Subcomm. on Total Force, House. Comm. on Armed Services*, 108th Cong. (2004) (statement of Kimberly Ann Stanish, National Military Veterans Alliance, Health Care Committee Co-Chair, and Benjamin Butler, National Association for Uniformed Services, Director of Legislation) (stating

unique, integrated nature of the military health care system. Appointment making processes differ by location. How direct care appointments were allocated between the contract and military treatment facilities for scheduling of patients, as well as how beneficiary priorities were accounted for in scheduling appointments differed by location as well.¹⁹⁸ As TRICARE implementation has progressed, and military treatment facilities work with the managed care support contractors, access to care has improved.¹⁹⁹ The Department of Defense continues to pursue new initiatives to improve patient access and thus satisfaction.²⁰⁰

f. Developing and Maintaining Adequate Civilian Provider Networks

In order to augment and supplement care provided at military treatment facilities, TRICARE's managed care support contractors are responsible for establishing and maintaining civilian provider networks to support the TRICARE Prime and Extra Options.²⁰¹ Within their respective regions, these contractors must establish networks in all military treatment facility catchment areas, all base realignment and closure sites and all noncatchment areas where the beneficiary population is large enough to justify a network.²⁰² Contractors found network development to be a challenge.²⁰³ Provider dissatisfaction resulted in significant provider

"[a]ccess to care is still the . . . number one concern."), at <http://armedservices.house.gov/openingstatementsandpressreleases/108thcongress/04-03-18butler.html>. But see Message from the Assistant Secretary of Defense for Health Affairs, Military Health System – Measures for Success, at http://www.ha.osd.mil/asd/mhs_measures.cfm (last updated July 23, 2003) (citing performance metrics for satisfaction with access to telephone care in the 80% range, slightly below target).

¹⁹⁸ *Observations on Proposed Benefit Expansion Hearing*, *supra* note 39, at 15-16.

¹⁹⁹ Compare DEP'T OF DEF., EVALUATION OF THE TRICARE PROGRAM FOR FY1999: FY2001 REPORT TO CONGRESS, 3-14 – 3-20 (2002) (documenting beneficiary perceptions of availability of care in FY94 and FY99) with 2003 REPORT TO CONGRESS, *supra* note 10, at 16-20 (documenting trends from FY00 to FY02).

²⁰⁰ *Military Health System Hearing 2003*, *supra* note 36, at 5 (testifying on two new programs – TRICARE Online for online appointment scheduling, and "Open Access", which provides same-day routine and acute appointments to Prime enrollees).

²⁰¹ Letter from Stephen P. Backhus, Director, Veterans' Affairs and Military Health Care Issues, General Accounting Office, to The Honorable Stephen Buyer, Chairman, Subcommittee on Military Personnel, Committee on Armed Services, House of Representatives 3 (Mar. 13, 2000), at <http://www.gao.gov> (retrievable by Report # HEHS-00-64R).

²⁰² *Id.*

²⁰³ Contractors were required to build massive networks, usually spanning multiple states within a matter of a few months.

turnover during the initial years of TRICARE implementation.²⁰⁴ As the programs have stabilized, administrative requirements have lessened, and claims processing have improved, concerns over provider attrition should have lessened. Nonetheless, beneficiaries and providers are still expressing dissatisfaction,²⁰⁵ resulting in Congressional action directing the Department of Defense to improve its oversight and methodology to ensure civilian network adequacy.²⁰⁶ Not surprisingly, there have also been some deficiencies in more rural, underserved areas, similarly to those experienced by Medicare.²⁰⁷ Furthermore, an integrated direct and purchased care system as unique as the military's raises additional challenges regarding network adequacy. Considering the primary mission of the military health care system, and the inevitable occurrence of military medical deployments, what constitutes network adequacy can fluctuate greatly, depending on the capacity of the direct care system and resultant quantity of network referrals.

g. The Importance and Challenges of Partnership in an Integrated System

"[T]he core factor to success in the TRICARE program is the development of a partnership between the prime contractor, the

In some cases the Contractor is working in an area that is unfamiliar and where that company had no previous relationships with providers. Commercial managed care companies avoid some of the markets TRICARE is entering; because of their small size there is not much competition among healthcare providers. They simply have no interest in joining a managed care network when there is no financial incentive to do so. When a community has only one hospital, it is difficult to get that hospital to sign on to a network.

TRICARE Administration: Hearing Before the Subcomm. on Military Personnel, Sen. Comm. on Armed Services, 106th Cong. (1999) (statement of William J. Meyer, Senior Vice President, Palmetto Government Benefits Administrators (Blue Cross and Blue Shield of South Carolina)).

²⁰⁴ “[M]aintenance of networks will remain a challenge as reimbursements are among the lowest that civilian providers receive and as managed care continues to be resisted.” *TRICARE Program: Hearing Before Subcomm. on Military Personnel, House Comm. on National Security, 105th Cong. (1998)* (statement of Colonel Steve E. Phurrough, Lead Agent, TRICARE Central Region, U.S. Army).

²⁰⁵ GEN. ACCOUNTING OFFICE, GAO-03-928, OVERSIGHT OF THE TRICARE CIVILIAN PROVIDER NETWORK SHOULD BE IMPROVED 17 (2003), at <http://www.gao.gov> (retrievable by Report # GAO-03-928).

²⁰⁶ H.R. REP. NO. 108-106, at 338 (2003).

²⁰⁷ Backhus, *supra* note 201, at 2; GEN. ACCOUNTING OFFICE, GAO/HEHS-99-36, PHYSICIAN SHORTAGE AREAS: MEDICARE INCENTIVE PAYMENTS NOT AN EFFECTIVE APPROACH TO IMPROVE ACCESS (1999), at <http://www.gao.gov> (retrievable by Report # HEHS-99-36). These isolated difficulties, however, have not justified an overall increase in physician reimbursement rates. ACROSS-THE-BOARD PHYSICIAN RATE INCREASE, *supra* note 132.

military treatment facilities, the Lead Agent, the Department of Defense, and the Services."²⁰⁸

The integrated nature of the TRICARE managed health care system presented some unique leadership and management challenges,²⁰⁹ not to mention confusion.²¹⁰ With competing military missions and numerous stakeholders, multiple organizational structures, and competing needs for power and control over resources and personnel, TRICARE governance is particularly tricky.²¹¹ Moreover, one of the concerns expressed throughout the military's transition to managed care was whether the Department of Defense possessed the necessary expertise to contract for and run such a sophisticated program. As a result, Congress directed the Department of Defense to establish a health care management and administration program for military treatment facility commanders who were designated as regional lead agents and other appropriate individuals.²¹²

²⁰⁸ *Medical Issues: Hearing Before Subcomm. on Personnel, House Comm. on Armed Services*, 106th Cong. (2000) (statement of David J. McIntyre, Jr., President and CEO TriWest Healthcare Alliance).

²⁰⁹ Describing the relationship between lead agent and prime contractor, one lead agent testified:

We have disagreements, dissatisfaction with performance on both sides, and contractual issues that require negotiation of additional payments to the contractor or from the contractor to the government. These issues have always been addressed amicably and without rancor or disharmony. At times, this Region has provided resources to TriWest to accomplish tasks with which it was having difficulty. At other times, TriWest has provided additional resources without compensation to accomplish time sensitive tasks. We view each other as crucial members of a joint healthcare delivery team that is working to ensure that beneficiaries receive the high quality healthcare that they deserve.

TRICARE Program: Hearing Before Subcomm. on Military Personnel, House Comm. on National Security, 105th Cong. (1998) (statement of Colonel Steve E. Phurrough, Lead Agent, TRICARE Central Region, U.S. Army).

²¹⁰ S. REP. NO. 104-112, at 263 (1995):

The role of the TRICARE lead agent vis-à-vis the TRICARE contractor is unclear to the committee, and, we suspect, the lead agents themselves. Clearly, in the MHSS, the military lead agent should be considered the final authority. However, there are a large number of functions which can be accomplished more efficiently and more effectively by the TRICARE contractor. The committee believes that the issue of how responsibility is shared cannot be ambiguous and must be guided by military medical readiness and stewardship of the available resources. The Assistant Secretary of Defense and the Surgeons General must clearly define the sharing of responsibilities and ensure that there is no doubt or confusion of the part of the lead agents or the TRICARE contractors.

²¹¹ For a detailed discussion of the current organization structure and a comparison of organization in the private sector versus TRICARE, see HOSEK & CECCHINE, *supra* note 39, at 5-13 and 25-42 (observing that the TRICARE organization "displays few of the characteristics of civilian organizations" with respect to the health-plan function).

²¹² National Defense Authorization Act for Fiscal Year 1996, Pub. L. No. 104-106, § 715, 110 Stat. 186, 375 (1995). For more information on the program itself, see DEP'T OF DEF., VIRTUAL MILITARY HEALTH INSTITUTE:

The Department of Defense established the TRICARE Management Activity (TMA) within the Office of the Assistant Secretary of Defense for Health Affairs, with the goal of strengthening “program oversight and performance by developing and using specific performance measures for the program’s costs, quality, and health care access.”²¹³ Since its inception, the TRICARE governance structure has been modified in an ongoing effort to strengthen the partnership between the direct care infrastructure and the managed care support services contractors as well clarify the responsibilities, authority and accountability of the various system stakeholders, including the new TRICARE Regional Directors, Lead Agents, contractors, and individual military treatment facility commanders.²¹⁴

PROMOTING EXCELLENCE IN EXECUTIVE SKILLS FOR THE MILITARY HEALTH SYSTEM, 2002 CONGRESSIONAL REPORT (2002).

²¹³ *Operational Difficulties and System Uncertainties*, *supra* note 166, at 11.

²¹⁴ For additional information, see *Defense Health Program House Hearing 2004*, *supra* note 1 (written statement of William Winkenwerder, Jr., MD, MBA, Assistant Secretary of Defense for Health Affairs) (discussing the latest TRICARE governance structure); Memorandum from Deputy Secretary of Defense for Assistant Secretary of Defense (Health Affairs) (Jan. 20, 2004), at http://www.ha.osd.mil/policies/2004/tricare_governance_guidance.pdf (discussing the new plan and directing immediate implementation).

h. Current TRICARE Benefit Structure

A brief summary of the three benefit programs as they currently exist is provided below:²¹⁵

TABLE 1

	TRICARE Prime		TRICARE Extra		TRICARE Standard	
Eligible Beneficiaries	Active duty family members ¹	Retirees & their families ²	Active duty family members	Retirees & their families ²	Active duty family members	Retirees & their families ²
Annual Deductible	\$0	\$0	\$150/ind. \$300/family ³	\$150/ind. \$300/family	\$150/ind. \$300/family ³	\$150/ind. \$300/family
Annual Enrollment	\$0	\$230/ind. \$460/family	\$0	\$0	\$0	\$0
Civilian Outpatient	\$0	\$12	15% of negotiated fee	20% of negotiated fee	20% of allowed charges	25% of allowed charges
Civilian Inpatient	\$0	\$11/day (\$25 min.)	> \$25 or \$13.32/day	< \$250/day or 25% of negotiated charges + 20% of negotiated professional fees	> \$25 or \$13.32/day	< \$441/day or 25% of billed charges + 25% of allowed professional fees
Catastrophic cap⁴	\$1000/yr	\$3000/yr	\$1000/yr	\$3000/yr	\$1000/yr	\$3000/yr
Basic Description	HMO – most care provided in MTFs, augmented by the preferred provider network		PPO – providers limited to network		Traditional CHAMPUS (FFS)	
Additional Points	<ul style="list-style-type: none"> ** least out-of-pocket costs. - Must reside in an area where Prime is offered. - Requires enrollment. - Care coordinated through PCM/referrals required. - Offers POS option⁵ 		<ul style="list-style-type: none"> - Copayment 5% less than Standard. - No balanced billing and no forms to file. 		<ul style="list-style-type: none"> - Non-participating providers may balance bill up to 15% above the allowable charge. - May also use TRICARE Extra. - Nonavailability statements may be required before civilian inpatient care may be obtained. 	

¹ The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 eliminated copayments (except mail order pharmaceutical benefits) for active duty dependents enrolled in Prime. Pub. L. No. 106-398, § 752, 114 Stat. 1654 (2000) (codified at 10 U.S.C. §1097a(e)).

² Retirees and their family members who reach age 65 are no longer eligible for TRICARE Prime, Extra or Standard but instead are eligible for TRICARE for Life and continued treatment in military treatment facilities and hospitals on a space available basis.

³ Junior enlisted families, paygrades E-4 and below, pay a discounted annual deductible of \$50/individual or \$100/family.

⁴ Includes annual deductibles, co-pays, inpatient and outpatient care and prescription cost shares.

⁵ TRICARE Prime POS option allows enrollees to obtain care from any authorized TRICARE provider without a referral from their PCM. Additional deductibles and cost-shares apply.

²¹⁵ Data obtained from the Department of Defense TRICARE website <http://www.tricare.osd.mil/>. Data is current for 2004. This chart is intended to provide a quick overview of the three primary options under TRICARE and is by no means a complete and detailed undertaking of all benefit particulars.

D. 21st Century Challenges

*"The military health care system has changed continually over the years as a result of legislative initiatives designed to enhance coverage for military beneficiaries."*²¹⁶

The Department of Defense's military health care system is anything but static. Challenges have continued into the 21st Century.²¹⁷ TRICARE benefits and eligible beneficiaries continue to expand.²¹⁸ The most significant changes involve retired, Medicare-eligible beneficiaries. Prior to the enactment of TRICARE for Life,²¹⁹ military retirees and their beneficiaries ceased to be eligible for CHAMPUS, and later TRICARE, benefits upon reaching the age of 65, at which point they became eligible for Medicare.²²⁰ Beginning in Fiscal Year 2002, TRICARE now serves as a second payer to Medicare.²²¹ The sole prerequisite is that beneficiaries must be enrolled in Medicare Part B.²²² If so enrolled, TRICARE for Life pays all out-of-pocket costs for Medicare covered services and will also pay for TRICARE covered services not covered by Medicare.²²³ There is no premium, deductible or copayments required other than the monthly cost of Medicare Part B itself. This new benefit covers roughly 1.5 million beneficiaries²²⁴ and added approximately \$3.0 billion in expenses to the military health care budget in 2003.²²⁵

²¹⁶ *Operational Difficulties and System Uncertainties*, *supra* note 166, at 11-12.

²¹⁷ See, e.g., *Defense Health Program House Hearing 2004*, *supra* note 1 (testimony of Vice Admiral Michael L. Cowan, Medical Corps, United States Navy Surgeon General):

I think that is has been a struggle for us all, particularly since '01, because of the rapid change in the benefit. . . . [I]f we could have a time to allow these oscillations of our patient behavior and our funding predictions to get in a more stable environment, then I think that we would all be much happier with our performance, our projections, our expectations and our ability to care for patients.

²¹⁸ DEP'T OF DEF., 2003 REPORT TO CONGRESS, *supra* note 10, at 2.

²¹⁹ National Defense Authorization Act for Fiscal Year 2001, Pub. L. No. 106-398, § 712, 114 Stat. 1654A-176 (2000) (amending 10 U.S.C. § 1086(d)).

²²⁰ 10 U.S.C. § 1086(d)(1) (2004).

²²¹ 10 U.S.C. § 1086(d)(2) (2004).

²²² 10 U.S.C. § 1086(d)(2)(A) (2004).

²²³ 10 U.S.C. § 1086(d)(3) (2004).

²²⁴ DEP'T OF DEF., 2003 REPORT TO CONGRESS, *supra* note 10, at 14.

²²⁵ CONG. BUDGET OFFICE, *supra* note 6, at ix.

Additionally, TRICARE Senior Pharmacy (TSRx), effective in 2001,²²⁶ provides a comprehensive pharmacy benefit to seniors.²²⁷ TRICARE for Life and TRICARE Senior Pharmacy benefits together account for approximately one-third of the Department of Defense's purchased health care costs.²²⁸

Most recently, Congress enacted a number of provisions to improve access and enhance health care benefits for military reservists and their families.²²⁹ Most notably, Congress extended temporary eligibility for TRICARE enrollment on a cost-share basis to non-mobilized reservists who otherwise lacked health insurance.²³⁰ The Department of Defense has not yet implemented this new benefit and has failed to budget for it in future years.²³¹ There have also been numerous other benefit enhancements the Department of Defense has had to incorporate into its managed care system.²³²

Simultaneously, there is continued pressure to downsize the direct care system through reductions in military end strength²³³ and concerns over the impact of the next round of base

²²⁶ National Defense Authorization Act of 2001, Pub. L. No. 106-398, § 711, 114 Stat. 1654A-175 - 176 (2000).

²²⁷ Prescriptions are filled for free at military treatment facilities and minimal co-payments (\$3 for generics and \$9 for brand name drugs) are required for drugs procured through purchased-care (through either the TRICARE mail order pharmacy or retail networks). For additional information on this benefit, see <http://www.tricare.osd.mil/pharmacy/seniorpharmacy.cfm>.

²²⁸ DEP'T OF DEF., 2003 REPORT TO CONGRESS, *supra* note 10, at 14.

²²⁹ National Defense Authorization Act for Fiscal Year 2004, Pub. L. No. 108-136, Title VII, Subpart A, 117 Stat. 1392 (2003).

²³⁰ 10 U.S.C. § 1076b (2004).

²³¹ See *Defense Health Programs: Hearing Before the Subcomm. on Personnel, Senate Comm. on Armed Services*, 108th Cong. 16 (2004) (statement of William Winkenwerder, Jr., MD, MBA, Assistant Secretary of Defense for Health Affairs), at <http://armed-services.senate.gov/statemnt/2004/March/Winkenwerder.pdf> [hereinafter *Defense Health Programs Senate Hearing 2004*] (expressing concern over the costs and effect of this new entitlement).

²³² See, e.g., National Defense Authorization Act of 2001, Pub. L. No. 106-398, Title VII, 114 Stat. 1654A (2000) (eliminating copayments for active duty members enrolled in Prime, extending TRICARE Prime Remote to active duty family members stationed in remote areas, providing permanent chiropractic health care benefits to active duty members).

²³³ Mark D. Faram, *Searching for Cuts in Shore Jobs*, NAVY TIMES, Feb. 23, 2004, at 8 (discussing Department of the Navy plans to "convert 1,775 enlisted and officer medical billets into civilian or contracted positions during fiscal 2005").

realignment and closures. Congressional action is prevalent in this area.²³⁴ “[T]he department’s annual spending on medical care [adjusted for the overall rate of inflation] almost doubled from 1988 to 2003, rising from \$14.6 billion to \$27.2 billion.”²³⁵ During this same period, the significant downsizing of the active duty military forces resulted in a 38 percent reduction in the size of the force.²³⁶ With enhanced benefits and expanding beneficiary populations, however, the reduction in active duty forces has not resulted in a decline in beneficiaries or health care costs.

IV. Analyzing the Continuing Challenges of System Mission, Design, and Market Limitations - This Isn’t Your Standard Employer-Sponsored Plan

The military health care system’s transition to one of managed care is nothing short of a tremendous undertaking with phenomenal complexity. There is no denying its unique nature. Despite its accomplishments to date, challenges remain. Arguably, an examination of some of the similarities and differences between this system and other federal health care purchasing models helps to explain why some federal health care purchasing programs are viewed as more successful than others. Success is difficult to define, however, unless put into context by an understanding of the health care system’s ultimate goals. True success may be elusive if not adequately and realistically defined. Depending on the context, success may mean cost effectiveness, maximization of market competition, beneficiary satisfaction or suitability as a

²³⁴ See, e.g., National Defense Authorization Act for Fiscal Year 2004, Pub. L. No. 108-136, § 726, 117 Stat. 1392 (2003) (concerned that future base closures may have an adverse impact on beneficiaries’ access to health care, Congress has required the establishment of a working group to plan for continuing health care for beneficiaries affected by BRAC 2005 closures); Department of Defense Appropriations Act, 2001, Pub. L. No. 106-259, § 8060, 114 Stat. 656 (2000) (prohibiting further reductions in civilian medical personnel assigned to military treatment facilities absent certification to Congress); National Defense Authorization Act for Fiscal Year 1991, Pub. L. No. 101-510, § 711, 104 Stat 1485, 1582 (1990) (prohibiting further reductions in both military and civilian medical personnel absent certification to Congress that such personnel were in excess of current and projected needs and such a reduction would not increase CHAMPUS costs).

²³⁵ CONG. BUDGET OFFICE, *supra* note 6, at ix.

²³⁶ *Id.*

model for universal application. One size does not necessarily fit all as a comparison between the Federal Employees Health Benefit Plan (FEHBP), as a representative model of employer-sponsored health plans, and TRICARE demonstrates. Evaluating the performance of TRICARE through the lens of the standard employer benefit plans neglects to account for the true differences in program goals.

Not surprisingly, because the FEHBP is often cited as an ideal model for health care reform, there have been repeated suggestions, bills introduced,²³⁷ studies mandated²³⁸ and even a demonstration project²³⁹ to examine the feasibility and efficacy of providing benefits under the FEHBP to all or a portion of military beneficiaries as an alternative to utilizing the military health care system. This approach would seem quite logical based on the perceived success of FEHBP. Such an approach, however, would require a severing of the dual missions either in whole or for certain beneficiary classes. As problematic as the military's resistance to mission severance is, so too is the unwillingness of beneficiaries to accept increased cost-sharing under the FEHBP.²⁴⁰

If anything, more similarities may be drawn between TRICARE and Medicare, as the two struggle to contain rising health care costs with only a limited ability to drive beneficiary and provider behavior. Medicare's egalitarian characteristics, coupled with a heavily regulated defined benefit and cost controls, have presented the program with ongoing challenges as it seeks

²³⁷ See, e.g., OFFERING FEHBP TO DOD, *supra* note 38 (reviewing 9 bills introduced in the 105th Congress to extend FEHBP to military beneficiaries).

²³⁸ See, e.g., National Defense Authorization Act for Fiscal Year 2000, Pub. L. No. 106-65, § 717, 113 Stat. 512, 692 (1999) (requiring a comparative report on health care coverage under TRICARE and FEHBP); National Defense Authorization Act for Fiscal Year 1993, Pub. L. No. 102-484, § 723, 106 Stat. 2315, 2440 (1992) (requiring a study of FEHBP to determine whether it would be a cost effective alternative).

²³⁹ Strom Thurmond National Defense Authorization Act for Fiscal Year 1999, Pub. L. No. 105-261, § 721, 112 Stat. 1920, 2061-65 (1998) (enacted at 10 U.S.C. § 1108 (mandating a three-year FEHBP demonstration project for Medicare-eligible military retirees)).

²⁴⁰ Enrollment in the demonstration project peaked at only 5.5 percent, with many beneficiaries indicating they believed they "had better benefits and lower costs than the coverage they could obtain from FEHBP." GEN. ACCOUNTING OFFICE, MILITARY RETIREE HEALTH BENEFITS: ENROLLMENT LOW IN FEDERAL EMPLOYEE HEALTH PLANS UNDER DOD DEMONSTRATION (2003), at <http://www.gao.gov> (retrievable by Report # GAO-03-547).

to capitalize on the benefits of managed care reform.²⁴¹ The Department of Defense's has sought to do the same and experienced some similar challenges. As two federally financed and heavily regulated health care programs, Congress has sought at times to utilize lessons learned from one program for the benefit of the other - Medicare experiences have driven the military health care system at times,²⁴² and vice versa.²⁴³ Unfortunately, neither has been completely successful at harnessing the health care industry, as both programs stand in stark contrast to the standard, post-ERISA deregulated employer sponsored health benefit plan.

A. The Added Complexities of Serving a Special Class of Beneficiaries and the Sense of Entitlement

While officially the Defense Health Program is still a discretionary budget program, funded by annual appropriations, it resembles and is treated as an entitlement program.²⁴⁴ Over the last 50 years, the military health system has evolved from a gratuitous benefit based on a moral imperative to essentially a highly regulated virtual entitlement program through numerous Congressional enactments and oversight.

While some may consider the military health care system just another employer-sponsored

²⁴¹ See, e.g., Butler & Moffit, *supra* note 59.

²⁴² For example, the CHAMPUS maximum allowable charge for provider reimbursement is directly tied to Medicare reimbursement rates. Additionally, when the Department of Defense continued to experience claims processing problems, it was believed they could benefit from the same procedures Medicare had used to solve their problem.

²⁴³ As evidenced by the Senate Finance Committee's April 2003 hearing on the purchasing of health care in a competitive environment. See *infra* notes 305 and 306 and accompanying text.

²⁴⁴ *Defense Health Program House Hearing 2004*, *supra* note 1 (testimony of Dr. William Winkenwerder, Jr., Assistant Secretary of Defense for Health Affairs). See also *TRICARE Program: Hearing Before Subcomm. on Military Personnel, House Comm. on Armed Services*, 107th Cong. (2001) (statement of David J. McIntyre, Jr., President and CEO, TriWest Health Alliance) ("Adding to this complexity is the fact that the DHP is essentially an entitlement program within the discretionary portion of the DoD budget."). With such a unique status, mixed signals are sent and interesting questions have arisen. For example, in investigating whether the Antideficiency Act applies to the obligations and expenditures of the defense health program, the General Accounting Office concluded "that DHP actions are 'authorized by law' regardless of the amount of available budgetary resources and do not violate the Antideficiency Act." Letter from Anthony H. Gamboa, General Counsel, General Accounting Office, B-287619, to The Honorable Jerry Lewis Chairman, Subcomm. on Defense, House Comm. on Appropriations 10 (July 5, 2001), at <http://www.gao.gov> (retrievable by GAO Decision # B-287619).

health care plan, the system is much more.²⁴⁵ These benefits are viewed as critical to recruiting and retaining the all volunteer military force of today. If anything, the military health care system resembles more of an egalitarian-type system.²⁴⁶ The distinctions in views, and resultant approach in utilizing the market, can be directly linked to many of the challenges experienced by the Department of Defense during its conversion to a system of managed care. In many ways, the Department of Defense has even less flexibility than the Medicare program does due to the very generous and uniform nature of military health care benefits.²⁴⁷

For example, the moral imperative notion permeates military health care and is repeatedly manifested in Congressional action²⁴⁸ and beneficiary attitudes.²⁴⁹ The result has been one of ever increasing benefits while costs to beneficiaries have remained lower than any other federal or private employer insurance program. Viewed as an important quality of life benefit for military families and the promise of a lifetime of health care for retirees, the military health care system's approach to cost containment in no way reflects that of the private sector, where beneficiaries are required to bear more and more of the cost of health care in an effort to make the consumer cost-conscious and control utilization. "Although DoD has adopted some of the same practices as private employers . . . the trend in DoD has generally been toward greater

²⁴⁵ See, e.g., *Tricare and Alternatives for Retiree Health Care: Hearing Before Subcomm. on Military Personnel, House Comm. on National Security*, 104th Cong. (1996) (statement of Rep. Robert J. Dornan, Chairman, Subcommittee on Military Personnel) (citing objective of "ensuring that the millions of Americans who steadfastly served this country continue to receive the medical care they so faithfully *earned*.")) (emphasis added).

²⁴⁶ For a more detailed discussion of the inherent tensions between market competition and modestly egalitarian social contracts, and the application of these policies to Medicare reform see ROSENBLATT, *supra* note 23, at 131-35, 374-77, and 407-10.

²⁴⁷ Considering the uniform nature of benefits provided under TRICARE in contrast with those offered under Medicare's various M+C managed care plans.

²⁴⁸ See, e.g., National Defense Authorization Act for Fiscal Year 1998, Pub. L. No. 105-85, § 752, 111 Stat. 1629, 1823 (1997) (expressing the sense of Congress that the US has incurred a moral obligation to provide health care for military retirees). Three years later, Congress enacted Tricare for Life.

²⁴⁹ See RICHARD A. BEST, JR., CONG. RESEARCH SERV., IB93103, ISSUE BRIEF FOR CONGRESS: MILITARY MEDICAL CARE SERVICES, 13 (March 20, 2003), *temporarily at* <http://hutchison.senate.gov/Health5.pdf> ("Specifically, these benefits are not viewed by some beneficiaries as an insurance program paid for in a market context, but rather as a benefit that is earned by the unique nature of demands inherent in performing military service.").

coverage and lower copayments and deductibles.²⁵⁰ Additionally, unlike the private sector, the Department of Defense can not simply raise premiums to adjust when the program costs exceed best budget estimates.²⁵¹

The ensuing challenges have been manifested in several significant ways. First, over-utilization continues to plague the military health care system, hampering its ability to more fully realize the benefits of managed care reform.²⁵² In addition to over-utilization by existing beneficiaries, the ever-increasing richness of benefits has continued to induce ghost beneficiaries, who while entitled were not utilizing military health care benefits, to drop their other forms of insurance and utilize TRICARE.²⁵³

Managed care in large part is based on the use of incentives, in the form of both carrots and sticks, to drive behavior. Throughout the experimentation with and ultimate implementation of managed care, the military health care system has been constrained in the range of incentives with which they could seek to drive beneficiary behavior. From a beneficiary standpoint, the original CHAMPUS benefits were quite generous with relatively small cost-sharing requirements, and the alternative - treatment in military treatment facilities - is free.

²⁵⁰ CONG. BUDGET OFFICE, *supra* note 6, at 10.

²⁵¹ *Defense Health Program House Hearing 2004*, *supra* note 1 (testimony of Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs).

²⁵² See SUSAN D. HOSEK ET. AL, RAND CORP, MR-401-1 OSD, THE DEMAND FOR MILITARY HEALTH CARE 4-5 (1995), at <http://www.rand.org/publications/MR/MR407.1>. See also RINGEL, *supra* note 63 (highlighting four key differences between demand for health care in general and in the military). A perfect example is the elimination of copays for active duty family members enrolled in Prime despite the existence of an earlier study indicating such a policy would result in increased utilization. Study findings predicted a 30 percent increase in outpatient use as a result of the elimination of the \$6 or \$12 PRIME copays. RICHARD D. MILLER, CTR. FOR NAVAL ANALYSIS, VOLUME TRADE-OFF FACTORS FOR THE MILITARY HEALTH SYSTEM (1999), at http://www.cna.org/research/pdfs/health/crm99_78.pdf.

²⁵³ See, e.g., *Defense Health Program House Hearing 2004*, *supra* note 1 (testimony of Vice Admiral Michael L. Cowan, Medical Corps, United States Navy Surgeon General) ("As the word of TRICARE's quality and effectiveness spreads, and as the cost of other insurance programs rise, more and more retirees under 65 are dropping other health insurance plans and relying on TRICARE. . . [T]his year we estimate 7 percent increase in the returning population.")

As managed care alternatives were considered and designed, the notion that there was already an entitlement under the original system limited the Department of Defense's ability to change existing benefits, namely the provision of free direct care, or to use negative incentives in order to draw beneficiaries away from the standard CHAMPUS benefits to a less costly form of managed care. For example, Congress instituted a prohibition on the collection of user fees for outpatient care provided at military treatment facilities to non-active duty beneficiaries.²⁵⁴ Additionally, when the Department of Defense sought to increase standard CHAMPUS cost-sharing and lock beneficiaries out of the direct care system who did not elect to voluntarily enroll in a managed care option, Congress took action to prohibit the use of these sticks.²⁵⁵ With free direct care and the cost of original CHAMPUS fee-for-service care relatively minimal, there was limited room within which the Department of Defense could work to make a managed care plan appear all the more attractive. As a result, military beneficiaries have a decreased incentive to switch between various plans, as the magnitude of the carrots and sticks themselves was relatively minor, and there was always the option of free space available care at military treatment facilities.

Interestingly, annual deductibles under CHAMPUS, and now TRICARE, have only been increased once since the original creation of the purchased care element in the military health care system.²⁵⁶ Furthermore, there are no enrollment fees for military beneficiaries, with the exception of retirees under the age of sixty five and their families who elect to enroll in

²⁵⁴ National Defense Authorization Act for Fiscal Year 1988, Pub. L. No. 100-180, § 722, 101 Stat. 1019, 1116 (1987); H.R. REP. NO. 100-58, at 217 (1987) (rejecting OMB's proposed user fee initiative). This two year prohibition has long since expired but direct care user fees have not been re-pursued.

²⁵⁵ National Defense Authorization Act for Fiscal Year 1993, Pub. L. No. 102-484, § 715, 106 Stat. 2315, 2437-38 (1992).

²⁵⁶ See H.R. REP. NO. 101-923, at 617 (1990) (Conference Report commenting on §712 in the National Defense Authorization Act for Fiscal Year 1991, PUB. L. NO. 101-510, which amended 10 U.S.C. § 1079(b) and § 1086(b) to increase the annual deductibles from \$50 to \$100/year for individuals and from \$150 to \$300/year for families). See also H.R. REP. NO. 101-665, at 292-93 (1990) (the House Armed Services Committee notes that “[i]n the meantime, the deductible for even the most generous private sector plans has increased many-fold.”).

TRICARE Prime.²⁵⁷ The Federal Employees Health Benefit Plan, by contrast, has sustained annual premium increases between 7.2% and 13% per year for the last seven years alone.²⁵⁸ Moreover, employee premium contributions for employer sponsored health care are significantly higher than the Department of Defense enrollment fees and deductibles.²⁵⁹

There are also some of the more traditional tensions present as well. The insurance market evolved in large part on the ability of private insurers to control costs through risk pooling and cherry picking of beneficiaries who present low risks, either directly or indirectly through the benefits and cost sharing arrangements offered.²⁶⁰ The military system's much more defined benefit, coupled with the winner take all approach to contracting, not to mention lack of beneficiary data during the first series of contracts, resulted in a reduced ability to both calculate and ultimately limit risk. The difficulty in calculating risk, coupled with the notion that the provision of military health care is a national responsibility, and thus somewhat egalitarian in nature, runs counter to the accepted forces of commercial insurance and market competition.²⁶¹ The combination of these factors resulted in contractors' willingness only to accept very narrow risk corridors in both CRI and TRICARE. Similarly, the Medicare Prescription Drug, Modernization and Improvement Act anticipates such risk sharing challenges and has incorporated risk corridor provisions into Medicare Advantage.²⁶²

B. The Challenges of Customization and Heavy Regulation

²⁵⁷ If such an election is made, however, there is no annual deductible under TRICARE Prime. *See supra* Table 1.

²⁵⁸ TRCARE Health Plan Comparison with Federal Employees Health Benefits Program, Premium Increases 1998-2004, at <http://www.tricare.osd.mil/TRICAREcomparisons/admin/FEHBP.cfm>. The compounded effect of these amounts to a 94.9% cumulative increase. *Id.*

²⁵⁹ See THE KAISER FAMILY FOUND. AND THE HEALTH RESEARCH AND EDUC. TRUST EMPLOYER, EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY, Section 6 (2003), at <http://www.kff.org/insurance/ehbs2003-abstract.cfm>. *See also* CONG. BUDGET OFFICE, *supra* note 6, at 8-9.

²⁶⁰ See Bryan Ford, *The Uncertain Case for Market Pricing of Health Insurance*, 74 B.U. L. REV. 109, 121-29 (1994) (discussing the transition from community-rating to experience-rating for health insurance).

²⁶¹ ROSENBLATT, *supra* note 23, at 132-33.

²⁶² Pub. L. No. 108-173, § 221(c), 117 Stat. 2066 (2003).

The managed care insurance industry continues to operate as an off-the-shelf product.²⁶³ As a result of the deregulation of health care through the enactment of ERISA²⁶⁴ and the subsequent judicial interpretations of that statute,²⁶⁵ large employers sought to apply basic demand side market principles to the purchase of health care.²⁶⁶ “To employers the contractual approach to healthcare procurement seemed only natural: most of their day-to-day purchasing of other types of goods and services was done on such a basis.”²⁶⁷ In this sense, the Department of Defense also sought to apply their normal procurement process to healthcare, as it has to other products and services. The difference, however, is the military’s highly-regulated, excruciatingly detail-oriented procurement approach found itself at odds with the deregulated, free market approach of the commercial managed care industry.

To say that the Department of Defense’s significant customization requirements and heavy regulation greatly enhance the degree of difficulty is an understatement. At the core of these demands for customization is the military health care system’s dual mission, which sometimes results in claims that neither mission is done well. Managed care support contractors become part of an integrated system of health care delivery and must work to maximize utilization of the direct care system. Furthermore, beneficiaries frequently bounce between military and civilian providers, with enrollment required for only one of the three TRICARE plans. All of these factors limit the natural operation and power of the market.²⁶⁸

²⁶³ Clark C. Havinghurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. 47, 65 (1994) (viewing health care as a “fungible commodity, that a purchaser identifies simply by pointing to the shelf on which are stacked the desired products”).

²⁶⁴ Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 832 (1974).

²⁶⁵ *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (distinguishing between insured and self insured plans for purposes of the ERISA deemer clause).

²⁶⁶ ROSENBLATT, *supra* note 23, at 550.

²⁶⁷ Weiner & Lissovoy, *supra* note 9, at 77-78.

²⁶⁸ “Three strategies for competing in health care markets appear to be important: increasing market share, increasing market power, and achieving efficiencies.” Paul B. Ginsburg, *The Dynamics of Market-Level Change*, 22

With almost nine million beneficiaries, the military would appear to have significant market power. Much of this power is illusory however, as the direct care system is responsible for roughly seventy percent of the care provided.²⁶⁹ Market power is further diluted by division of the market into regional contracts and the difficulty of guaranteeing a specified level of business with any degree of certainty. Providers are enticed to join networks and accept reduced fees in exchange for a more stable patient volume.²⁷⁰ The military's fluid beneficiary population and lack of universal enrollment, however, make any such guarantee all the more difficult to quantify. Furthermore, military beneficiaries have opportunities that are not available to beneficiaries in employer-sponsored plans or other civilian health care systems. With the exception of enrollment in TRICARE Prime, beneficiaries are free to choose a mixture of military and civilian care through the use of space-available care at military treatment facilities and the ability to utilize TRICARE Standard and Extra essentially as they see fit.²⁷¹ With TRICARE accounting for only a small portion of many providers' income, government cost controls and added administrative burdens of the program have an even greater impact on provider willingness to accept TRICARE than they do on Medicare.

Where managed care relies in large part on managed competition, the Department of Defense's regional, winner-takes-all approach to contracting arguably reduces competition at

J. HEALTH POL. POL'Y & LAW 363, 368 (1997). Arguably, TRICARE's system design eliminates the first two strategies for potential bidders and greatly limits the third.

²⁶⁹ DEP'T OF DEF., 2003 REPORT TO CONGRESS, *supra* note 10, at 52.

²⁷⁰ Kentucky Assoc. of Health Plans, Inc. v. Miller, 123 S. Ct. 1471, 1474 (2003) (discussing network providers incentives).

²⁷¹ In keeping with the Congressional trend of provided enhanced beneficiary freedom and choice, Congress eliminated the requirement for military beneficiaries to obtain nonavailability statements prior to seeking outpatient care through TRICARE Standard. National Defense Authorization Act for Fiscal Year 1997, Pub. L. No. 104-201, §734, 110 Stat. 2422, 2598 (1996) (amending 10 U.S.C. 1080 and 1086). See also H.R. Rep. 104-563, at 321 (1996):

"The committee believes that beneficiaries who decline enrollment in the HMO option of the TRICARE program do so in order to retain their freedom of providers, at a much greater cost to them in the form of deductibles and copayments. The requirement for obtaining non-availability statements may compromise these beneficiaries freedom of choice, as well as their continuity of care when an extensive outpatient procedure is required."

several levels. First, the high degree of customization, cost to submit a proposal and winner-takes-all approach to contract award result in a reduced number of bidders per regional contract.²⁷² Furthermore, once a contract is awarded there is no competition with other plans within the region – there is a single contractor who offers plans to beneficiaries. Where available, the beneficiary may choose between an HMO option, a PPO network and the traditional CHAMPUS fee-for-service, in addition to the ability to obtain free treatment on a space available basis at military treatment facilities. Unlike most private employers, the FEHBP and even Medicare+Choice, military beneficiaries are not provided with multiple HMO and PPO plans from which to choose, they have only a single option within each type of managed care plan. Finally, under the single contractor's umbrella of triple option managed care plans, the incentives between the plans are fairly small for beneficiaries. Consequently, both horizontal and vertical competition is limited to some extent through the military's customization of its system. In an effort to better integrate their systems of direct and purchased care, however, and to ensure military treatment facilities are operating under the same incentives as the civilian providers, TRICARE Prime provides some enrollees with an option of choosing between a military or civilian primary care manager, thereby creating internal competition within the system between military health care providers and civilian-provided care.²⁷³

²⁷² The CHAMPUS Reform Initiative is a prime example. Most recently, during the latest round of contracting for the next generation of TRICARE contracts, potential offerors also expressed concerns that there was a preference for existing contractors, making it more difficult for new offerors to enter the military arena. See *Senate Finance Hearing, supra* note 61 (statement of Lois E. Quam, Chief Executive Officer, Ovations, A UnitedHealth Group Company).

²⁷³ *TRICARE Progressing, supra* note 167, at 4. An example of such an effort by the Department of Defense is the introduction of family centered care. *Defense Health Programs Senate Hearing 2004, supra* note 231, at 12. While this has caused military providers to elevate their care and patient satisfaction levels in order to remain competitive, if the goal is to maximize the treatment being provided in military treatment facilities, which DoD believes to be the most cost-effective, one could question whether such an approach is consistent with the Department's underlying goals, especially in TRICARE Prime, the least expensive and most tightly controlled of the health care options.

Another challenge the military health care system continues to face is the incompatibility of customization and heavy regulation with normal free market forces. The more customized, prescriptive and heavily regulated the benefit, the less flexibility the market has to try and contain costs and utilize innovative strategies.²⁷⁴ The TRICARE contracting experiences of the mid-1990s support this premise. Additionally, there is extensive statutory and regulatory language governing the military health care system²⁷⁵ and significant Congressional oversight.²⁷⁶ Following the enactment of ERISA, and the resultant deregulation of the health care market in large respects, employers are largely free from governmental interference in their decision-making regarding the provision of employer-sponsored health care. The Department of Defense's experience reveals a sharp contrast, as the program has been governed by extensive legislative activity and subjected to heightened public scrutiny.

The administrative costs of customization are another factor worth consideration.²⁷⁷ There is a direct corollary between the degree of customization, and its associated difficulties, and an escalation in administrative costs.²⁷⁸ For any given system, the challenge is to determine the

²⁷⁴ Cf. Clark R. Havinghurst, *Is the Health Care Revolution Finished?*, 65 LAW & CONTEMP. PROBS. 1, 4 (2002) (A managed care plan's ability to control costs is also influenced by state and federal regulation as well as potential exposure to legal liability.).

²⁷⁵ See Chapter 55 of Title 10, United States Code, and 32 C.F.R. Part 199.

²⁷⁶ For over 15 years, Title VII in each annual National Defense Authorization Act has addressed health care issues. Language is frequently included in the annual Defense Appropriations Acts as well. Additionally, from 1985 through 1996, Congress conducted over 200 hearings on military and veterans' health care related topics. Interestingly, spikes in the number of annual hearings conducted occurred in both the mid-1980s, when the Department of Defense began contemplating transitioning to a form of managed care, and again in 1993, when debates on the President's national health reform proposals were at their height. The data used here were originally collected by Frank R. Baumgartner and Bryan D. Jones, with the support of National Science Foundation grant number SBR 9320922, and were distributed through the Center for American Politics and Public Policy at the University of Washington and/or the Department of Political Science at Penn State University. Neither NSF nor the original collectors of the data bear any responsibility for the analysis reported here. The data, compiled as part of an ongoing exhaustive study of all congressional hearings is available in searchable format at <http://www.policyagendas.org/resources/citation.html>.

²⁷⁷ RESEARCH HIGHLIGHTS, *supra* note 111, at 3 (answering the question, "On the basis of experience in the civil sector, DoD turned to managed care for cost control and, in the [CRI] demonstration's first two years, wound up spending more instead. What went wrong?").

²⁷⁸ See, e.g., Gardner, *supra* note 168, at 49: "Meanwhile, an internal Defense Department budget document said administrative costs have grown from 4% of total healthcare costs before TRICARE implementation to 18% now

appropriate equilibrium, given the system's missions and goals.²⁷⁹

C. Major Barriers to Full Market Participation

Major barriers to full market participation have become a reoccurring theme during both the CRI demonstration project and TRICARE program implementation. Many of the lessons learned from the initial nationwide implementation of TRICARE focused on contracting difficulties. Many of these challenges are directly attributable to the immense amount of customization demanded by the Department of Defense and the unique way in which they went about purchasing health care from the market.

These contracts necessitated large, complex and lengthy proposals.²⁸⁰ For example, one offeror's complete proposal entailed 33,000 pages.²⁸¹ Companies were spending several million dollars just to prepare and submit a bid for one of the regional contacts.²⁸² It is not surprising with this level of investment that every TRICARE contract award has been protested by a losing bidder, at significant cost to the government.²⁸³ The contract structure and its overly prescriptive requirements also limit a contractor's ability to be innovative and to use industry best practices, instead resulting in inefficiencies and ultimately increased costs.²⁸⁴ Nonetheless, these detailed

that several contracts are functioning. The document said administrative expenses have wiped out savings from more efficient healthcare delivery under TRICARE."

²⁷⁹ Cf. Havinghurst, *supra* note 263, at 56:

An ironic development in the health care cost controversy is the recent outcry over the high administrative costs incurred in the United States health care system. A large fraction of these costs are incurred by payers in efforts to bargain with providers and manage utilization. Such efforts, although precisely the kind of cost-containment actions that the policies of the 1980's were designed to stimulate, are necessarily costly. From the complaints being heard today about the magnitude of these costs and the burdens they impose on providers, one could infer that some kind of equilibrium may have been reached and that additional administrative efforts by payers would not yield savings exceeding their costs.

²⁸⁰ *Operational Difficulties and System Uncertainties*, *supra* note 166, at 4 ("DoD's managed care procurement process is extremely costly, complex, and cumbersome for all affected.").

²⁸¹ *Lessons Learned Hearing*, *supra* note 164, at 5.

²⁸² *Id.*

²⁸³ *Id.*

²⁸⁴ *Id.* at 6 (highlighting examples of overly prescriptive requirements including emphasis on processes vice health outcomes and archaic requirements for manual utilization review of claims despite the fact that the contractor is the one at risk).

contracting procedures were believed necessary by the Department of Defense.²⁸⁵

In addition to the cost to submit a proposal, contractors have had to respond to numerous change orders. By the middle of 2000, over 1000 contract change orders had been made by the Department of Defense due to new initiatives or changes in law and regulations.²⁸⁶ These contract adjustments, in addition to bid price adjustments have led to significant funding shortfalls and program instability for the Department of Defense.²⁸⁷ In an effort to provide more stability in the managed care support contracts, Congress amended 10 U.S.C. § 1073 to require the Secretary of Defense to implement all changes on a quarterly basis, to the maximum extent practicable.²⁸⁸ Conferees also urged the Department to consider implementing a policy to further limit changes.²⁸⁹

All of these factors have a negative impact on competition and to the extent that the Department of Defense is seeking to utilize the power of the market to increase the quality of health care and decrease costs, it will need to simplify its contracting approach as much as feasible. “Most, including DOD, feel the current contracts are too large, complex, and prescriptive in nature, limiting innovation and competition.”²⁹⁰ Furthermore, with respect to system design itself, the Department of Defense is faced with a Hobbesian choice: to utilize large and complex regional contracts in an effort to maximize uniformity and purchasing power while easing contract oversight for the Department or to manage smaller and potentially simpler

²⁸⁵ “DoD officials recognize that prospective contractors are frustrated with the process but consider the detailed procurement specifications, contracting process, and associated costs to be reasonable because of the size of the contracts and the need to establish a uniform program nationwide.” *DoD’s Program Continues to Face Challenges*, *supra* note 160, at 6.

²⁸⁶ *Lessons Learned Hearing*, *supra* note 164, at 7 (changes included everything from specific billing procedures for certain kinds of care to significant benefit expansions).

²⁸⁷ In 2001, the Department of Defense settled the outstanding contract disputes from the late 1990s for \$2.1 billion. CONG. BUDGET OFFICE, *supra* note 6, at 7. See also *Lessons Learned Hearing*, *supra* note 164, at 7.

²⁸⁸ National Defense Authorization Act for Fiscal Year 2000, Pub. L. No. 106-65, § 725, 113 Stat. 512, 698 (1999) (amending 10 U.S.C. §1073 by added paragraph (b)).

²⁸⁹ H.R. REP. NO. 106-301, at 772 (1999) (recommending changes to benefits be made annually to coincide with the beginning of the fiscal year to allow sufficient time to both prepare for and inform beneficiaries of benefit changes).

²⁹⁰ *Lessons Learned Hearing*, *supra* note 164, at 2.

contracts in an effort to better mirror the practices of the civilian sector. Either choice presents unique management challenges.²⁹¹

V. Future Considerations for TRICARE Reform

A. Evaluation of the Next Generation of TRICARE Contracts

One would hope that as the Department of Defense gains experience with TRICARE contracts, lessons learned from the current contract shortcomings would be addressed in designing future TRICARE contracts and to a large extent the Department of Defense has tried to do just that with assistance from the health care industry.²⁹² Many of the guiding principles were adopted from previous lessons learned in an effort to simplify the process and maximize competition.²⁹³ To be less cumbersome on all, oral presentations by offerors replaced the

²⁹¹ *Lessons Learned Hearing*, *supra* note 164, at 10-11.

²⁹² Beginning in 1998, the Department of Defense began focusing on designing a new and improved contract vehicle. Their efforts were originally entitled Tricare 3.0. Following three years of development, the contract proposals were withdrawn when contractors indicated that the new contracts were still more prescriptive than anticipated and the structure of the financial penalties and incentives was less than desirable. The Department rededicated itself to this task and their efforts resulted in what have been termed the next generation of TRICARE contracts ("T-Nex"). The current process is a much more open process with participation from industry. *Senate Finance Hearing*, *supra* note 61 (statement of Tom Carrato, Deputy Assistant Secretary of Defense for Health Plan Administration and COO for the TRICARE Management Activity) ("The procurement was developed in an open process, with input from industry and beneficiaries. Comments and questions from potential offerors were incorporated into evolving draft documents posted on an Internet site for public review."). *See also* <http://www.tricare.osd.mil/pmo/t-nex/documents.cfm>. For example, potential offerors were able to submit questions on the solicitation electronically to the contracting officer and those questions along with the Department's answers were posted on the website. A total of 1380 questions were submitted and answered, *at* <http://www.tricare.osd.mil/Contracting/Healthcare/Solicitations/index.cfm?fuseaction=main.faq&RecordID=22&SolicitationID=MDA906-02-R-0006>.

²⁹³ The Department of Defense articulated their guiding principles as follows:

- We will develop Request For Proposals (*RFPs*) that are simpler and easier to understand, to ensure maximum competition for our business, and contracts that are less complex to administer.
- We will develop performance-based requirements, clearly defining our ultimate needs rather than simply listing our expectations. This will allow us to take advantage of innovative problem solving approaches already proven by our contractors, which we may not have envisioned.
- We will establish separate contracts (carve-outs) when it is in the best interests of the Government and our beneficiaries. We will organize work logically by core competencies.

voluminous submissions of old.²⁹⁴ Contractors share risk with the government for health care costs²⁹⁵ and continue to receive fixed fees for administrative costs. The incentive structure has been realigned to provide strong incentives for customer service and beneficiary, provider and regional director satisfaction.²⁹⁶

The number of regional contracts has been cut from seven to three in an effort to enhance portability, reduce administrative costs and simplify contract administration.²⁹⁷ Carve-outs are used to simplify the contracts “through selective identification of functions and services that can be more easily administered through single, nationwide contracts, or through more focused, local solutions.”²⁹⁸ Nationwide contracts, including a national pharmacy mail order contract, a national retail pharmacy services contract, a TRICARE dual eligible fiscal intermediary contract to process TRICARE for Life claims, and a marketing and education products contract,²⁹⁹ will allow for uniformity and maximum utilization of the Department’s purchasing power. Local support contracts for services including utilization management, appointing and transcription

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- We will take advantage of lessons learned. For example, we will strive to *eliminate redundancies, minimize risks, confine reporting to what really matters*, continually reduce program weaknesses and make the best possible use of Government and contractor resources.

TRICARE Next Generation Program Document, at [http://www.tricare.osd.mil/pmo/t-nex/t-nex/Next_Generation_\(Final_Revision\).doc](http://www.tricare.osd.mil/pmo/t-nex/t-nex/Next_Generation_(Final_Revision).doc) (emphasis added).

²⁹⁴ Senate Finance Hearing, *supra* note 61 (statement of Tom Carrato, Deputy Assistant Secretary of Defense for Health Plan Administration and COO for the TRICARE Management Activity).

²⁹⁵ A detailed discussion of the exact formula and methodology are beyond the scope of this paper, however, the basic structure involves establishing target healthcare pricing, with the government and contractor sharing in both gains and losses based on a comparison of actual costs to negotiated target costs. For additional details, see CAPT Walter Tinling, MSC, USN, “T-Nex” The Next Generation of Contracts Briefing 13-24 (Oct. 26, 2003), at <http://www.tricare.osd.mil/conferences/2003/downloads/CaptWalterTinling.pdf>.

²⁹⁶ Senate Finance Hearing, *supra* note 61 (statement of Tom Carrato, Deputy Assistant Secretary of Defense for Health Plan Administration and COO for the TRICARE Management Activity); CAPT Walter Tinling, MSC, USN, “T-Nex” The Next Generation of Contracts Briefing (Oct. 26, 2003), at <http://www.tricare.osd.mil/conferences/2003/downloads/CaptWalterTinling.pdf>.

²⁹⁷ Department of Defense Fact Sheet, Next Generation of TRICARE Contracts, at <http://www.tricare.osd.mil/Factsheets/viewfactsheet.cfm?id=185>.

²⁹⁸ Senate Finance Hearing, *supra* note 61 (statement of Tom Carrato, Deputy Assistant Secretary of Defense for Health Plan Administration and COO for the TRICARE Management Activity).

²⁹⁹ TRICARE Fact Sheet, Summary of Next Generation of TRIARE Contracts, at <http://www.tricare.osd.mil/Factsheets/viewfactsheet.cfm?id=185>.

services³⁰⁰ will allow local, customized solutions.³⁰¹ Faced with a Hobbesian choice regarding size and complexity of contracts, the Department of Defense's new multi-faceted approach has allowed it to reap some of the benefits of each approach.

These efforts culminated with the Department of Defense issuing a Request for Proposal for the next generation of TRICARE managed care support services contracts in August 2002 with contract award in August 2003. Not surprisingly, all three contract bid awards were protested by losing bidders. All three awards, however, have been upheld.³⁰² The new contracts will be phased in within each region during 2004. The immediate challenge the Department will face is to achieve a seamless transition between contracts.³⁰³

Despite the changes that were made to the next generation of TRICARE contracts, they still deviate from the market norm in many respects and are thus still viewed as undesirable by some in the insurance industry.³⁰⁴ Interestingly, as Congress debated Medicare reform last session, the Senate Committee on Finance solicited testimony from large federal and private sector health care purchasers, including the Department of Defense, as well as from industry, to explore the

³⁰⁰ CAPT Walter Tinling, MSC, USN, "T-Nex" The Next Generation of Contracts Briefing (Oct. 26, 2003), at <http://www.tricare.osd.mil/conferences/2003/downloads/CaptWalterTinling.pdf>.

³⁰¹ "A major lesson learned is that localized contract management and oversight work well for health care delivery. Implementation of policy and program benefits is more effectively managed at the local level where there is the best understanding of regional needs." *TRICARE Contracts: Hearing Before Subcomm. on Military Personnel, House Comm. on Armed Services*, 107th Cong. (2001) (statement of Kenneth L. Farmers, Jr., Lead Agent, TRICARE Northwest, Region 11).

³⁰² Department of Defense, Managed Care Support Services (MCSS) Solicitation No. MDA906-02-R-006, available at <http://www.tricare.osd.mil/contracting/healthcare/solicitations/index.cfm?fuseaction=main.solview&recordid=22&SolicitationID=MDA906-02-R-0006>.

³⁰³ *Defense Health Program House Hearing 2004*, *supra* note 1 (opening statement of Representative John McHugh, Chairman):

By the end of 2004, the Defense Health Program will have undergone really a colossal effort – during time of war, of course – of transitioning billions of dollars worth of existing contracts in new and very different contracts. And I think it's important we ensure that the transition to the new contracts in no way negatively impacts beneficiary health care, and that, hopefully, it improves optimization of military treatment facilities while providing and preserving high-quality, accessible health care.

³⁰⁴ Whether the system is more attractive, or simply less unattractive, is in the eye of the beholder.

issue of purchasing health care services in a competitive environment.³⁰⁵ The hearing was designed to examine “how a competitive model might – or might not – work for Medicare.”³⁰⁶ Among other things, the Committee sought to examine different and distinct approaches to the purchase of health care, including the TRICARE winner takes all approach and an approach similar to that of the FEHBP where all qualified carriers are accepted.³⁰⁷

Most tellingly, a senior executive at UnitedHealth explained why, after investing considerable time and resources, they decided not to submit a bid on the next generation of TRICARE contracts and why the application of such a winner take all model to Medicare would be less than desirable.³⁰⁸ “There were many things we liked about the TRICARE solicitation, and we think it should provide significant improvements in the program. However, from our point of view, the solicitation was not structured in a manner that supported our three principles of effective competition.”³⁰⁹ UnitedHealth testified that they believed the solicitation favored incumbent contractors³¹⁰ with its process oriented, highly customized approach, and limited contractors’ ability to achieve best value under the contract.³¹¹

³⁰⁵ *Senate Finance Hearing, supra* note 61 (statement of Sen. Max Baucus, Ranking Member, Chairman, Sen. Comm. on Finance).

³⁰⁶ *Id.* (statement of Sen. Chuck Grassley, Chairman, Sen. Comm. on Finance).

³⁰⁷ *Id.* (statement of Sen. Max Baucus, Ranking Member, Chairman, Sen. Comm. on Finance).

³⁰⁸ *Id.* (statement of Lois E. Quam, Chief Executive Officer, Ovations, A UnitedHealth Group Company).

³⁰⁹ *Id.*

³¹⁰ Not surprisingly, four months later when the Department of Defense awarded the next generation of TRICARE managed care support services contracts, all three winners were incumbent companies. Triwest, awarded the Western region Nex-T contract, currently holds the contract for the Central Region. Humana, winner of the Southern Nex-T contract, currently services regions 3 and 4. HealthNet, formerly Foundation Health Systems, currently controls three contracts covering 5 regions, and was awarded the Northern Nex-T contract.

³¹¹ Explaining the tremendous risk to contractors and general instability of the TRICARE program, Ms. Quam testified:

Contractors are at risk for target health care costs, yet they have no control over many key decisions and factors that could impact TRICARE costs. These factors include benefit changes, implementation of best practices across the direct care system, major policy changes and structural changes to the MHS. *Under this arrangement, the contractors assume tremendous risk while DoD maintains control of circumstances necessary for cost control and penalty avoidance.* This approach creates a gross misalignment of interests and negative practices, such as change orders.

Senate Finance Hearing, supra note 61, at 7 (statement of Lois E. Quam, Chief Executive Officer, Ovations, A UnitedHealth Group Company) (emphasis added).

Clearly efforts have been made in the next generation of TRICARE contracts to bring them more in line with industry practices. Those efforts, however, have been limited by the continued demand for customization through integration. Thus the unique structure of the military health care system thwarts, to a degree, efforts to maximize market participation, optimization and thus competition.

B. Further Considerations

Escalating health care costs, beneficiary demands, and budget constraints will necessitate a review of the very nature of the military health care system on several fronts. First, is it a benefit or entitlement? This question, and its answer, will continue to bedevil both Congress and the Department of Defense through future budget cycles.³¹²

[T]he MHS is facing significant fiscal pressures. Thus, proposals to expand the program should be carefully crafted to avoid further erosion of the financial condition of the MHS. Also, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between wants, needs, and what individuals and our nation can afford. This concept applies to all major aspects of government including decisions about military health care. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of the military health system for current and future generations within a broader context of also providing for other important DOD and national needs.³¹³

Further compounding the problem, more and more military beneficiaries are utilizing the system due to the ever increasing richness of benefits, hampering the Department's ability to control health care costs.³¹⁴ The trend to date has clearly been one of increasing military benefits and

³¹² Concerns have also been expressed that as added benefits are contemplated, "the effect that any changes might have on establishing permanent claims and, thus future resources" must also be considered. *Observations on Proposed Benefit Expansion Hearing*, *supra* note 39, at 17.

³¹³ *Id.* at 13.

³¹⁴ "Defense health program costs continue to rise. In 2003, we experienced a 7 percent increase in new users and we expect the same this year in 2004. The growth is the result of increased use of Tricare by our eligible beneficiaries." *Defense Health Programs Senate Hearing 2004*, *supra* note 231 (testimony of William Winkenwerder, Jr., MD, MBA, Assistant Secretary of Defense for Health Affairs).

entitlements, irrespective of national health care insurance trends. With active Congressional committees of jurisdiction, virtual guaranteed annual legislative vehicles in the form of the Department of Defense authorization and appropriations acts, frequent congressional hearings where testimony from beneficiary advocacy groups is solicited, and a genuine respect for the contributions and sacrifices of military service members and their families, this trend comes as no surprise. As budget constraints mount, this trend may be in jeopardy,³¹⁵ although any such effort to trim back benefits will surely be an uphill battle. More likely, consumer driven options which emphasize increased cash compensation in exchange for higher out-of-pocket costs for health care may be proposed to slow growth and more closely resemble civilian sector trends.³¹⁶

The appropriate size and structure of the military health care system has consumed years of debate³¹⁷ and is sure to continue. Continuing pressure to reduce active duty end strength and military infrastructure,³¹⁸ coupled with a shifting beneficiary population, make further reductions in the military's direct care system virtually guaranteed. Furthermore, history has proven that these competing dual missions frequently result in the sacrificing of one for the other. One must question whether the benefits of this continued struggle are worth the costs, as the direct care system is further downsized.³¹⁹

³¹⁵ Rick Maze, *Pentagon Officials Dampen Hopes for Benefits Boosts*, NAVY TIMES, at 20 (March 15, 2004):

Senior Pentagon officials are making a concerted effort to dampen bipartisan fervor for improving military pay and benefits, especially for reservists and retirees. "We discourage the expansion of entitlements and the creation of new ones," said David S.C. Chu, undersecretary of defense for personnel and readiness, in March 2 testimony before a Senate subcommittee. The burden of paying for congressional mandates such as Tricare coverage for older retirees . . . is huge, he said.

"We want to focus attention on those still on active duty, not those who are finished with active duty."

³¹⁶ Some such suggestions have already been made. CONG. BUDGET OFFICE, *supra* note 6 (suggesting consideration of increased cash compensation packages combined with incrementally more expensive health insurance options).

³¹⁷ *Observations on Proposed Benefit Expansion Hearing*, *supra* note 39, at 13-14.

³¹⁸ The next Congressionally-authorized round of base realignment and closures is scheduled for 2005. Defense Realignment and Closure Act of 1990, Pub. L. No. 101-510, 104 Stat. 1808 (1990), *amended by* National Defense Authorization Act for Fiscal Year 2002, §3001, Pub. L. No. 107-107, 115 Stat. 1012, 1342 (2001).

³¹⁹ If history repeats itself, wartime medical readiness may once again find itself sacrificed in order to quell the immediate demands for peacetime care in a reduced capacity system.

The costs and benefits, and the very necessity, of the military health care system's unique structure should be considered in the context of reexamining its dual mission and the possibility of partial or total severance. Is an integrated system really required to achieve combat readiness, or are other methods available?³²⁰ Short of severance, other efforts may be pursued as well to ensure maximum utilization of military treatment facilities, through resource sharing, personal service contracting and other mechanisms to fully utilize capacity. All of these efforts presuppose of course that the Department of Defense's assertion that direct care is more cost effective than purchased care remains accurate as the 21st century proceeds. This continued assertion begs the question of whether training requirements are what is really driving the integrated nature of the military health care system or whether the prospect of cost savings is the driving factor. Surely, if the prospect of cost savings is the driving force, such a universal aspiration does not necessitate the creation and maintenance of such a complex, *sui generis* health care system.³²¹

Short of large scale reform in the nature of dual mission severance or entitlement reductions, small scale reforms may be pursued as well to continue to optimize efficiencies by maximizing market characteristics, expanding resource sharing arrangements, and harnessing the power of new technologies. Furthermore, regardless of the unique way in which the Department of Defense entered the market for health care services, and the challenges created by its demand for customization, it also faces challenges shared with the rest of the nation. The Congressional

³²⁰ See Robert A. Levy and Richard D. Miller, CTR. FOR NAVAL ANALYSIS, THE IMPLICATIONS OF UNIVERSAL ENROLLMENT FOR THE DOD HEALTH CARE SYSTEM (2000), at <http://www.cna.org/research/pdfs/health/crm457.pdf>. The study evaluated a number of options for a universal enrollment system for military health care, including providing non-active duty beneficiaries with FEHBP benefits and no access to the direct care system. In evaluating the impact on readiness of a reduced number of users of military treatment facilities, the study concluded "the loss of population would not create a significant problem for most specialties, but there would be problems for general surgery, orthopedic surgery and emergency medicine." *Id.* at 5-6. These concerns could potentially be addressed through other mechanisms, including support and training affiliation agreements with civilian institutions.

³²¹ A detailed examination is warranted to determine whether the direct care system is in fact more cost-effective, and if so, why.

Budget Office observes that the Department of Defense's increase in medical spending is not unique and may be attributable to the national escalation in health care costs:

Some critics view the growth in DoD's medical spending as an indication that the department needs to manage its health care dollars more efficiently, increasing the amount of health care provided per dollar. But this analysis finds that however efficient or inefficient DOD may be in using its health care resources, the observed growth in spending (adjusted for changes in the department's accounting methods and changes in the size and mix of DoD's population of beneficiaries) has been consistent with the growth in per capita health care spending in the U.S. population as a whole over the past 15 years.³²²

A complete solution cannot be achieved by the Department of Defense alone. No one is immune and larger issues loom for the Untied States as a whole as we continue to struggle with how to address and ultimately curb the escalating growth in health care spending.

Conclusion

*Though the program is sometimes wrought with overwhelming complexities and seemingly endless crises, we did not during creation, nor do we now, lose sight of the fact that what we all do has deep purpose and meaning and carries with it an awesome responsibility . . . a responsibility to the men and women who serve in defense of our freedom and to their readiness for duty.*³²³

The military health care system has undergone a tremendous transformation and made great progress in improving military beneficiaries' access to quality health care but the transformation has been anything but smooth, as the public spotlight on this program has revealed. The Department of Defense's experiences in part are reflective of the trial and error the entire nation was experiencing with managed care concepts at the end of the twentieth century. It also provides a fascinating case study of a major purchaser's attempts to bend the insurance market to

³²² CONG. BUDGET OFFICE, *supra* note 6, at 2. The Congressional Budget Office calculates 56% of the total growth in spending per active-duty member over the last 15 years is attributable to national changes in health care costs in general; 41% is attributable to the shift in mix of beneficiary population and accrual financing (which are unlikely to recur); and the remaining 3% is the net effect of a variety of offsetting factors from changes within the military health care system including enhanced benefits and gained efficiencies. *Id* at ix-x.

³²³ TRICARE Program: Hearing Before Subcomm. on Military Personnel, House Comm. on Armed Services, 107th Cong. (2001) (statement of David J. McIntyre, Jr., President and CEO, TriWest Health Alliance).

its needs and the results, including continued movement towards meeting the insurance industry halfway. A uniquely customized health care system like the Department of Defense's system exacerbates the challenges of transformation to managed care.

The ongoing struggles and policy dilemmas facing the Department of Defense are not unique, as the country and our political leaders continue to debate the desirability, and feasibility, of privatization and the appropriate role of the market in government-sponsored entitlement programs. Medicare is facing some of the same challenges the Department of Defense is in its attempt to contain costs and harness the power of a competitive market. The Centers for Medicare and Medicaid Services is busily working on implementing the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 with high hopes for market participation in Medicare Advantage.

Meanwhile, Federal Reserve Chairman Alan Greenspan recently "warned that the federal government 'has promised more retirement benefits than it can pay for' and 'to avoid damaging the economy in the future' it must consider reducing spending on entitlement programs such as Medicare."³²⁴ This will be a tough sell.³²⁵ Any attempt to trim back military health care benefits will be an equally tough sell as Congressional oversight committees have repeatedly demonstrated their devotion to military compensation and quality of life issues, frequently irrespective of Administration requests, and beneficiary advocacy groups are articulate, well-organized and quite powerful.

Questions regarding the Department of Defense's willingness to consider bifurcating

³²⁴ Henry J. Kaiser Family Found., *Federal Government Should Cut Entitlement Programs, Including Medicare, Not Increase Taxes to Address Federal Deficit, Greenspan Says*, Kaiser Daily Health Pol'y Rep. 1 (Feb. 26, 2004). See also *The Economic Outlook and Current Fiscal Issues: Hearing Before House Comm. on Budget*, 108th Cong. (Feb. 25, 2004) (statement of Alan Greenspan, Chairman, Board of Governors of the Federal Reserve System), at <http://www.house.gov/budget/hearings/greenspanstmnt022504.pdf>.

³²⁵ See Joseph J. Schatz, *Hill Not Biting on Greenspan's Social Security Bait*, CQ TODAY (Feb. 25, 2004); Nell Henderson, *Fed Chief Urges Cut in Social Security*, WASH. POST, at A1 (Fe. 26, 2004).

their health care delivery systems and the extent to which they will seek to trim back entitlements to more accurately resemble those of standard employer provided health care are sure to continue. "It is important, however, in the design of [a] program, that policy makers fully understand the misleading effects of thinking of a health care payment plan as a form of insurance and understand the limits to market based solutions."³²⁶ Likewise, there are similar market limitations that must be understood in the context of the current military health care system.

Even in a customized, egalitarian-driven system, it is important to have realistic expectations and prioritized goals. Understanding where changes can be made within the current structure to maximize mission, beneficiary and provider satisfaction and contain costs and the inherent limitations of such an entitlement program is critical. Only then can success be truly measured. As currently designed, it is intellectually inconsistent to make straight comparisons between the FEHBP and TRICARE. One is not necessarily better than the other. They are simply diverse programs, pursuing different public policy goals, within a broad spectrum of health care financing and delivery mechanisms. TRICARE finds itself in the precarious position of managing its health care entitlement under a discretionary budget program, attempting to contain costs on an ever expanding benefit and beneficiary population, and seeking to capitalize on market principles notwithstanding heavy government regulation. Some may just label such an endeavor mission impossible.

As budgetary pressures continue, both Congress and the Administration will have to consciously balance the costs and benefits of this uniquely structured entitlement

³²⁶ Bryan Ford, *The Uncertain Case for Market Pricing of Health Insurance*, 74 B.U. L. REV. 109, 143 (1994) (discussing designing a plan for universal health care coverage).

program to determine whether integration of the dual mission and continued classification of military health care as an “earned entitlement” vice a civilian-equivalent employee benefit are worth the added cost, or whether a paradigm shift is in order.

As the nation moves forward in the twenty-first century, health reform is anything but static. “To account for continuing and rapid changes in the nature of managed care,” astute scholars have best described the state of affairs as “the continuing transformation of managed care.”³²⁷ For all its warts, “there is no going back to the unmanaged care that managed care replaced.”³²⁸ The only remaining question then, is how Congress and the Department of Defense will proceed forward with managed care for military beneficiaries in the face of these challenges. Only time will tell.

*I believe that our benefit always should be better, and it should be better because of the sacrifice that our men and women who are in uniform today, as well as our retirees, have made to their country. But there is the issue of how much different can it afford to be?*³²⁹

³²⁷ RAND E. ROSENBLATT, SARA ROSENBAUM & DAVID M. FRANKFORD, LAW AND THE AMERICAN HEALTH CARE SYSTEM 280 (Supp. 2001-2002).

³²⁸ John V. Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 ST. LOUIS U. L.J. 397, 409 (2003).

³²⁹ Defense Health Program House Hearing 2004, *supra* note 1 (testimony of William Winkenwerder, Jr., MD, MBA, Assistant Secretary of Defense for Health Affairs).